Petition

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No.

In The
Supreme Court of the United States
October Term, 1981

Planned Parenthood Association Of Kansas City,
Missouri, Inc., Naim S. Kassar, M.D.,
Reproductive Health Services and Allen S. Palmer, D.O.,
Petitioners,

vs.

John Ashcroft, Attorney General of the State of Missouri,
and Ralph L. Martin, Prosecuting Attorney of Jackson
County, Missouri,
Respondents.

On A Writ Of Certiorari To The
United States Court of Appeals For The
Eighth Circuit

PETITION FOR CERTIORARI

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THE QUESTION PRESENTED FOR REVIEW

Whether the Appellate Court erred in upholding the constitutionality of Missouri Revised Statutes, §188.028.1 and §188.028.2(1), (3), (4), (5) and (6) by construing the same to statutorily require the approval of one parent or of the juvenile court for an unemancipated minor under eighteen years of age to terminate her pregnancy, even if she is found by the juvenile court to be mature enough to make her own personal decision; although such interpretation is contrary to the plain language of the statute and is contrary to the interpretation placed thereon by the District Court?

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PLANNED PARENTHOOD ASSOCIATION OF KANSAS CITY,
MISSOURI, INC., NAIM S. KASSAR, M.D.,
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On A Writ Of Certiorari To The
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PETITION FOR CERTIORARI

OFFICIAL REPORTS OF OPINIONS BELOW

The District Court opinion is reported at 483 F.Supp. 679 (W.D. Mo. 1980).

The Appellate Court's interlocutory opinion is reported at 655 F.2d 848 (8th Cir. 1981).

STATEMENT OF JURISDICTIONAL GROUNDS

The judgment sought to be reviewed was issued and filed on November 30, 1981. The final judgment of November 30, 1981 incorporated the prior interlocutory judgment of July 8, 1981. Jurisdiction of this Honorable Court is predicated upon Title 28 United States Code, § 1254(1) and §2101(c).

CONSTITUTIONAL AND STATUTORY PROVISIONS INVOLVED

The Fourteenth Amendment to the United States Constitution, in relevant part.

> "Section 1. All persons born or naturalized in the United States, and subject to the jurisdiction thereof, are citizens of the Untied States and of the State wherein they reside. No State shall make or enforce any law which shall abridge the privileges or immunities of citizens of the United States; nor shall any State deprive any person of life, liberty, or property, without due process of law; nor deny to any person within its jurisdiction the equal protection of the laws."

Missouri Revised Statutes, §188.028

> **"188.028. Minors, abortion requirements and procedure**
>
> 1. No person shall knowingly perform an abortion upon a pregnant woman under the age of eighteen years unless:
>
> (1) The attending physician has secured the informed written consent of the minor and one parent or guardian; or
>
> (2) The minor is emancipated and the attending physician has received the informed written consent of the minor; or

(3) The minor has been granted the right to self-consent to the abortion by court order pursuant to subsection 2 of this section, and the attending physician has received the informed written consent of the minor; or

(4) The minor has been granted consent to the abortion by court order, and the court has given its informed written consent in accordance with subsection 2 of this section, and the minor is having the abortion willingly, in compliance with subsection 3 of this section.

2. The right of a minor to self-consent to an abortion under subdivision (3) of subsection 1 of this section or court consent under subdivision (4) of subsection 1 of this section may be granted by a court pursuant to the following procedures:

(1) The minor or next friend shall make an application to the juvenile court which shall assist the minor or next friend in preparing the petition and notices required pursuant to this section. The minor or the next friend of the minor shall thereafter file a petition setting forth the initials of the minor; the age of the minor; the names and addresses of each parent, guardian, or, if the minor's parents are deceased and no guardian has been appointed, any other person standing in loco parentis of the minor; that the minor has been fully informed of the risks and consequences of the abortion; that the minor is of sound mind and has sufficient intellectual capacity to consent to the abortion; that, if the court does not grant the minor majority rights for the purpose of consent to the abortion, the court should find that the abortion is in the best interest of the minor and give judicial consent to the abortion; that the court should appoint a guardian ad litem of the child; and if the minor does not have private counsel, that the court should appoint counsel. The petition shall be signed by the minor or the next friend;

(2) Copies of the petition and a notice of the date, time, and place of the hearing shall be personally served upon each parent, guardian or, if the minor's parents are deceased and no guardian has been appointed, any other person standing in loco parentis of the minor listed in the petition by the sheriff or his deputy. If a parent or guardian or, if the minor's parents are deceased and no guardian has been appointed, any other person standing in loco parentis cannot be personally served within two days after reasonable effort, the sheriff or his deputy shall give constructive notice to them by certified mail to their last known address, and the hearing shall not be held for at least forty-eight hours from the time of the mailing. In any case where there exists the potential or appearance of conflict of interests between the parents or guardian or next friend of the child and the child, the court shall appoint a guardian ad litem to defend the minor's interest. The court shall set forth, for the record, the grounds for such appointment;

(3) A hearing on the merits of the petition, to be held on the record, shall be held as soon as possible within five days of the filing of the petition. If any party is unable to afford counsel, the court shall appoint counsel at least twenty-four hours before the time of the hearing. At the hearing, the court shall hear evidence relating to the emotional development, maturity, intellect and understanding of the minor; the nature, possible consequences, and alternatives to the abortion; and any other evidence that the court may find useful in determining whether the minor should be granted majority rights for the purpose of consenting to the abortion or whether the abortion is in the best interests of the minor;

(4) In the decree, the court shall for good cause:

(a) Grant the petition for majority rights for the purpose of consenting to the abortion; or

(b) Find the abortion to be in the best interests of the minor and give judicial consent to the abortion, setting forth the grounds for so finding; or

(c) Deny the petition, setting forth the grounds on which the petition is denied;

(5) If the petition is allowed, the informed consent of the minor, pursuant to a court grant of majority rights, or the judicial consent, shall bar an action by the parents or guardian of the minor on the grounds of battery of the minor by those performing the abortion. The immunity granted shall only extend to the performance of the abortion in accordance herewith and any necessary accompanying services which are performed in a competent manner. The costs of the action shall be borne by the parties.

(6) An appeal from an order issued under the provisions of this section may be taken to the court of appeals of this state by the minor or by a parent or guardian of the minor. The notice of intent to appeal shall be given within twenty-four hours from the date of issuance of the order. The record on appeal shall be completed and the appeal shall be perfected within five days from the filing of notice to appeal. Because time may be of the essence regarding the performance of the abortion, the supreme court of this state shall, by court rule, provide for expedited appellate review of cases appealed under this section.

3. If a minor desires an abortion, then she shall be orally informed of and, if possible, sign the written consent required by section 188.039 in the same manner as an adult person. No abortion shall be performed on any minor against her will, except that an abortion may be performed against the will of a minor pursuant to a court order described in subdivision (4) of subsection 1 of this section that the abortion is necessary to perserve the life of the minor."

STATEMENT OF THE CASE

Missouri Revised Statutes, § 188.028 became law on June 29, 1979, as part of a comprehensive package of abortion regulation contained in Chapter 188. The challenged Section requires the written consent of one parent or of the juvenile court to an abortion for an unemancipated minor under 18 years of age. A temporary restraining order was issued against enforcement of the challenged Section on June 30, 1979.

The District Court declared the challenged Section unconstitutional (483 F.Supp. 679, 687-690 [W.D. Mo. 1980]) (A-12-A-17) and the Appellate Court reversed holding the Section constitutional (655 F.2d 848, 857-860 [8th Cir. 1981]) (A-65-A-70) (incorporated into final order of November 30, 1981) (A-117).

Both Petitioners' and Respondents' witnesses acknowledged that this challenged Section might well engender delays of 13 days or more, forcing many minors to pass into the second trimester and thereby exposing them to substantially increased risks of morbidity and mortality.

Petitioners' experts were unanimous in their belief that mandating parental involvement in all instances was not in the best interests of the minor, abortion patient population. (T. 135, Palmer). "The younger the minor * * * the later she will be in her gestation when she seeks abortion services. The less available the abortion service, the longer she will wait. So it will tend to increase her risks rather than serve her health interest." (T. 352, Crist). Dr. Kretzschmar concurred that such a requirement is not "in the best interest of that patient population under the age of 18" (T. 390), as did Dr. Vera (T. 446).

Respondents' experts also agreed that this challenged Section would on occasion not be in the best interests of the minor. (T. 511, Ketterman). Respondents' expert Dr. Nathanson was also concerned with the health risks imposed by the delay he envisioned of "(s)omething on the order of two weeks" (T. 644), as was Respondent's expert Dr. Schmidt who acknowledged the possibility of danger in the Section's absolutism (T. 832). Respondents' expert Dr. Sym recognized that for a "significant percentage" of minors the delays imposed "would not be in their best health interests" (T. 915) and that the challenged Section imposes "a burden upon the delivery and availability of abortion services" (T. 916).

Petitioners' expert witnesses detailed the disproportionate impact this challenged Section would have upon the availability and delivery of abortion services to minors. This would be so because minors by reason of hospital imposed requirements of parental consent would be deprived of hospital abortions in Missouri, and secondly, because minors delay in seeking medical assistance for abortion by reason of psychological denial, and lack of sophistication and resources. Dr. Crist, drawing upon federal govenment statistics, testified that "50 per cent of the women age 12 and under who seek abortion services are pregnant by incest". (T. 351).

Petitioners' expert witnesses testified that the additional office visit required of minors under §188.028.2(1), prior to seeking court approval, would increase the total cost of the procedure by $10.00 to $25.00, by $35.00 (T. 219, Kassar), $15.00 to $50.00 (T. 350, Crist). They further testified that this challenged Section interferes with the traditional doctor-patient relationship (T. 135, Palmer; 392, Kretzschmar; 445, Vera) and seriously burdens the availability and delivery of abortion services (T. 135, Palmer; T. 324, Smith; T. 392, Kretzschmar; T. 446, Vera). Respondents' expert Dr. Ketterman stated in conclusion, "I am not in favor of this law exactly as it is written . . .", it "places a burden upon the delivery and availability of abortion services." (T. 513). Respondents' expert Dr. Nathanson also stated he could not support this challenged Section requiring parental involvement in all cases, thereby removing from the physician the ability to act in each case for the best interests of his or her patient. (T. 642).

It was Dr. Smith's considered opinion that "the minor herself is the best judge of whether her parents should be notified or not before she consents to abortions." (T. 313). Respondents' expert Dr. Sym approved of the Section in backhanded fashion, for he felt that a physician could fail to comply with it "if the doctor had a very good reason" and later "he would be able to defend himself against these charges successfully". (T. 912). He acknowledged that "many parents would fail to support a minor's decision to abort." (T. 922).

No two witnesses in the entire trial could agree on what the term "emancipated" in §188.028.1(2) means, and the same is not defined by the statute. Dr. Palmer had no idea of the criteria for emancipation (T. 136) and was aware of 14 year old women capable of giving an informed consent (T. 137). Dr. Kassar questioned "(i)f the person can calculate up to ten * * * or tell me a good joke * * * I don't understand it." (T. 218). "I wouldn't know how to determine that. * * * It is confusing." (T. 294), Smith). "I wouldn't know how to use the emancipated portion of it." (T. 349, Crist). "It confuses me." (T. 445, Vera). The Appellate Court's reference (655 F.2d at 860 n.15, A-70) to *Wurth* v. *Wurth,* 322 S.W.2d 745, 746 (1959) offers little guidance or relevance. The ability or appropriateness of any given minor to consent to her abortion is unrelated to her financial dependence upon her parents as the sole controlling criterion.

Respondents' experts were equally perplexed. "(A) young woman who is in any way still in need of guidance and advice and help from her parents * * * is not truly an emancipated person * * * (f)or the purposes of this section" (T. 498, Ketterman), as far as the definition of emancipated "I am really lost" (T. 501, Ketterman). "(E)ither marriage or prior birth is determinant" of emancipation (T. 647) Nathanson). "I can only guess", there would have to be "a prior legal proceeding in which the minor has been officially adjudicated to be emancipated". (T. 911, Sym).

The built-in delays of this challenged Section are enormous. A typical pattern of prompt compliance might well reflect a minor, who previously having realized her pregnant state, having consulted her parents and been refused consent, receiving the required information from the facility all on delayed day one. She must then file pleadings with the court on day two (§188.028.2[1]), allow for service on her parents on days three and four (§188.028.2[2]), allow for mailing or notice on days five and six (§188.028.2[2]), have a court hearing and decision on day seven (§188.028.2[3]-[4]), have an appeal filed on day eight (§188.028.2[6]), allow for perfection and decision on appeal on days nine through 14 (§188.028.2[6]) and then await an indeterminable period of time for an appellate decision and any subsequent appeal processes.

No other Missouri statute exists regulating any other medical or surgical procedure in this fashion; and this challenged Section applies to abortion at all stages of pregnancy. Dr. Kassar related the Missouri experience in 1974-1976 when parental involvement was mandated.

> "First the patient went out of the state and * * * we lost her. Second, the patient always comes late by the time they tell their parents. Third, some kids got kicked out of home, and, you know, some come with bruised eyes after they told their parents, and they come late. And some they never told their parents and they run away." (T. 217).

Dr. Smith related a case in which the parent refused consent to the minor because the parent wanted the child to raise and a three week delay ensued. (T. 296). Dr. Crist was also concerned that mandated "parental involvement would jeopardize * * *" the minor patient's "well being". (T. 351). He felt that parental involvement in such cases "would increase her anxiety * * *" and "the greater her anxiety and changes in body metabolism, her ability to cooperate with the medical setting, those contribute to an increased risk of complications and problems." (T. 352). As Respondents' expert Dr. Ketterman observed, "young women have gone into labor, a full-term pregnancy * * * never having admitted to themselves or anyone else that they were pregnant." (T. 482).

The basis for federal court jurisdiction of this matter in the first instance was Title 28, United States Code, §1343(3) and Title 42, United States Code, §1983. (483 F.Supp. at 682, A-1).

ARGUMENT

This challenged Section attempts to impede and to frustrate abortions for minors by forcing them to wend their way through a maze of parental and judicial involvement, necessitating requirements, loss of anonymity and delays adverse to their best health interests. Women under the age of 18 constitute a large portion of the abortion population. (Twenty-eight percent of Petitioner Reproductive Health Services' patients are under 18 years of age. [T. 12, Widdicombe]. In Dr. Kretzschmar's practice, as Chair of Obstetrics and Gynecology at both Truman Medical Center and at the University of Missouri Medical School at Kansas City, 65% of the patients are under 18 years of age [T. 390] and in Petitioner Dr. Palmer's practice, one-third (T. 149].

Minors delay seeking medical assistance, thereby increasing the dangers to their health, by reason of "the requirement of parental consent." (T. 25, Widdicombe).

This challenged Section blatantly violates the specific holdings of this Honorable Court in *Planned Parenthood of Central Missouri* v. *Danforth,* 428 U.S. 52 (1976) and in *Bellotti* v. *Baird,* 443 U. S. 622 (1979) (*Bellotti, II*).

Initially in 1974, Missouri sought to require parental consent for all unmarried minors under the age of 18. This Honorable Court in *Danforth, supra,* struck down that provision in 1976 noting,

> "* * * the State does not have the constitutional authority to give a third party an absolute, and possibly arbitrary, veto over the decision of the physician and his patient to terminate the patient's pregnancy, regardless of the reason for withholding the consent.
>
> * * * *

> "Any independent interest the parent may have in the termination of the minor daughter's pregnancy is no more weighty than the right of privacy of the competent minor mature enough to have become pregnant." 428 U.S. at 75.

In response to this Honorable Court's decision, Missouri enacted the present challenged Section. The thrust of this effort is again to frustrate the exercise by minors of their constitutional rights, by requiring the unnecessary encumbrances of parental and/or judicial confrontation. What this Honorable Court said in 1976 is equally true today in regard to §188.028. Even the State itself may not retain the arbitrary right of veto over a mature minor's abortion; and parental interests of any level may never outweigh the minor's interests of privacy.

Two years ago, this Honorable Court held invalid a Massachusetts statute, which for all purposes here is identical to this challenged Section, enacted weeks prior to that decision.

> "Although it satisfies constitutional standards in large part, §12S falls short of them in two respects: First, it permits judicial authorization for an abortion to be withheld from a minor who is found by the superior court to be mature and fully competent to make this decision independently. Second, it requires parental consultation or notification in every instance, without affording the pregnant minor an opportunity to receive an independent judicial determination that she is mature enough to consent or that an abortion would be in her best interests." *Bellotti, supra,* 443 U.S. at 651.

Both of these constitutional infirmities are present throughout this challenged Section. As Respondent's expert witnesses acknowledged, §188.028.2(4) permits the court to deny the minor's petition, even though she may be capable of giving her own consent. (T. 505, Ketterman). The permissible orders by the court under §188.028.2(4) in subsections (a) through (c) *are all independent alternatives, joined by the disjunctive "or".*

Parental involvement is mandated in all cases, regardless of the minor's best interest. See: §188.028.1(1); and §188.028.2(1), (2), (5) and (6).

> "Moreover, the potentially severe detriment facing a pregnant woman, see *Roe* v. *Wade,* 410 US at 153, is not mitigated by her minority. Indeed, considering her probable education, employment skills, financial resources, and emotional maturity, unwanted motherhood may be exceptionally burdensome for a minor. In addition, the fact of having a child brings with it adult legal responsibility, for parenthood, like attainment of the age of majority, is one of the traditional criteria for the termination of the legal disabilities of minority. In sum, there are few situations in which denying a minor the right to make an important decision will have consequences so grave and indelible. *Bellotti, supra,* 443 U.S. at 642.

Similar provisions for minors' consents as contained in §188.028 have been declared unconstitutional by the Seventh Circuit, for reasons similarly applicable here. In *Wynn* v. *Carey,* 582 F.2d 1375 (7th Cir. 1978), an unanimous Appellate Panel held,

> "The State's concern that a minor receive parental guidance about a prospective abortion is undermined when a significant segment of pregnant minors is not afforded that guidance. In short, the statute distinguishes between two classes of minors without any showing of justification for the distinction.
>
> * * * *
>
> "* * * a pregnant minor who chooses to give birth may consent to any medical or surgical treatment without the necessity of parental consent* * * * That legislation presumes that pregnant minors are sufficiently knowledgeable and mature to consent knowingly. The State has suggested no reason why pregnant minors are less

> capable of deciding whether to terminate their pregnancy than they are to decide whether to carry their pregnancy to term, or even to have a Caesarian section, a far more dangerous procedure than a first trimester abortion. We hold, therefore, that the Act, at least in regard to the objective of the informed decisions, is underinclusive because it excludes married minors and overinclusive because it includes mature and emancipated minors." 582 F.2d at 1387.

The challenged Section in this cause suffers identical infirmities. In Missouri, any minor can consent to carry a pregnancy to term, regardless of her emancipation. Missouri Revised Statutes, §431.061.1(4)(a). This challenged Section is underinclusive for it excludes minors who have left or deserted their parents' home and live alone, regardless of their age, maturity, intelligence, education or experience; and, in fact, encourages pregnant minors to flee their family and homes to obtain summarily the status of emancipation. It is overinclusive for it includes minors who may be married, divorced or widowed with prior children, if they remain unemancipated by living with their parents, dependent upon them for support.

The Appellate Court in *Wynn, supra,* noted that,

> "The parents' right to know is therefore in direct conflict with the minor's right of privacy. . . . such notice frequently might be inconsistent with a minor's best interests.[24] That it may not be in the minor's best interest to have her parents informed of her condition in all cases is recognized by the Illinois General Assembly. A number of statutes enable minors to receive medical care without the parents being informed. For example, a minor can receive birth control devices and treatment for venereal disease and drug use without parental notice. * * * Legislation of this type recognizes that in certain situations when minors may be hesitant to inform their parents of their condition,

> enabling those minors to obtain counseling and medical care without involving their parents may not only be in their best interests but may also serve the public interest in assuring that medical care is provided.
>
> "* * * The objectionable feature of the statute is rather that it requires that the parents be informed in *all* cases, thereby precluding an independent assessment, whether by a court or physician, that it would not be in the minor's best interests for her parents to learn of her condition.
>
> > "24. There are a variety of reasons why it could be inconsistent with a minor's best interests to have one or both of her parents know of her pregnancy. For example, parents may physically abuse the minor upon disclosure of the pregnancy. Rather than inflicting physical harm, parents may force the pregnant minor to enter into a marriage which she does not want. Others may compel the minor to continue her pregnancy simply as punishment." 582 F.2d at 1388. See the complete, extended discussion in *Wynn,* 582 F.2d at 1388-1390.

The Missouri General Assembly similarly has determined that minors should be allowed treatment for drug, pregnancy and venereal disease, free from parental involvement. Missouri Revised Statutes, §431.061.1(4)(a-c).

The omission of the word "health", in conjunction with the word "life" as included in the last line of §188.028.3 is also fatal to subsection 3. See: *Roe* v. *Wade,* 410 U.S. 113, 165; and, *Planned Parenthood of Central Missouri, supra,* 428 U.S. at 68 at note 9.

Bellotti, II, supra, imposed one additional requirement upon statutes which attempt to establish an alternative judicial bypass for parental consent.

> "The proceeding in which this showing is made *must assure* that a resolution of the issue, *and any appeals* that may follow, *will be completed with anonymity and sufficient expedition to provide an effective opportunity for an abortion to be obtained.* In sum, *the procedure must ensure* that the provision requiring parental consent does not in fact amount to the 'absolute, and possibly arbitrary veto' that was found impermissible in Danforth." (Emphasis supplied). 443 U.S. at 644.

The challenged Section's provisions do not in any manner *ensure* a prompt determination at either the trial court level (§188.028.2[4]) nor at the appellate level (§188.028.2[6]). In fact, regarding appeals, the matter of expedition is relegated to the future adoption of court rules by the State Supreme Court, contrary to the express command of this Honorable Court that such assurances be contained in the statute. No such rules have been enacted in the two and one-half years which have elapsed since the statute's enactment. Nor is anonymity *ensured* on appeal (or at the trial level) by the challenged Section.

Numerous courts have stricken identical provisions for many of the reasons enunciated in the District Court's well-reasoned opinion. (483 F.Supp. at 687-690, A-12-A-17). See: *Jones* v. *Smith,* 474 F.Supp. 1160, 1164-1167 (S.D.Fla. 1979), *affirmed* sub nom. *Scheinberg* v. *Smith,* 659 F.2d 476, 478-482 (5th Cir. 1981). *Akron Center For Reproductive Health, Inc.* v. *City of Akron,* 479 F.Supp. 1172, 1201-1202 (N.D. Ohio 1979), *affirmed,* 651 F.2d 1198, 1205-1206 (6th Cir. 1981); *Margaret S.* v. *Edwards,* 488 F.Supp. 181, 203 (E.D. La. 1980); and *Charles* v. *Carey,* 627 F.2d 772, 775 at n.2 (7th Cir. 1980).

> "We shall not belabor the constitutional question section 390.001(4)(a) presents, as the Supreme Court has resolved that issue. In *Bellotti* v. *Baird,* 443 U.S. 622, 99 S.Ct. 3035, 61 L.Ed.2d 797 (1979), the Court held that a state may require, alternatively, parental consent or

> judicial authorization before allowing an unmarried minor to secure an abortion. The Court specified, however, that judicial authorization *must* be given if the minor 'satisfies the court that she is mature and well enough informed to make intelligently the abortion decision on her own,' *id.* at 647, 99 S.Ct. at 3050, *or* if, absent this showing, the court determines that the abortion would nevertheless be in the minor's best interest. *Id.* at 647-48, 99 S.Ct. at 3050.
>
> "As we read subsection 4(a), its last sentence, '[t]he court *shall* determine the best interest of the minor and enter its order in accordance with such determination' (emphasis added), mandates that a Florida court base its authorization of a minor's abortion on what it finds to be the best interests of the minor, without regard to the minor's maturity. Thus, the provision runs directly afoul of *Bellotti* II, for 'it permits judicial authorization for an abortion to be withheld from a minor who is found by the . . . court to be mature and fully competent to make this decision independently.' *Bellotti* II at 651, 99 S.Ct. at 3052. If we reach the merits of plaintiff's claim, therefore, it is clear that subsection 4(a) must fall." *Scheinberg, supra* 659 F.2d at 480.

While the tortured construction of §188.028 by the Appellate Court might well produce a result permitted by *dicta* of *Bellotti II, supra,* it is clear that the District Court, as have numerous other courts, correctly interpreted the specific statutory language of §188.028 to produce results not constitutionally permissible and results which are directly counter to the admonitions of *Bellotti, II, supra.*

Two recent decisions by this Honorable Court reaffirm the time honored and constitutionally mandated principle that courts not act as superlegislatures and seek to redraft statutes under the guise of construction.

> "* * * it is an elemental canon of statutory construction that where a statute expressly provides a particular remedy or remedies, a court must be chary of reading others into it. 'When a statute limits a thing to be done in a particular mode, it includes the negative of any other mode.' " *Transamerica Mortgage Advisors, Inc.* v. *Lewis,* 444 U.S. 11, 19-20 (1979). See: *Kissinger* v. *Reporters Committee for Freedom of the Press,* 445 U.S. 136, 149 (1980).

It is imperative to recognize that the challenged Section was not an effort by the Missouri General Assembly to faithfully track this Honorable Court's opinion in *Bellotti II, supra,* decided on July 2, 1979. The challenged Section was passed by the Missouri General Assembly two weeks earlier on June 15, 1979. It is only by reason of the tortured construction placed upon the challenged Section by the Appellate Court, a construction that defies normal rules of grammar and customary definitions of words, a construction that strains in Procrustean fashion to bed the challenged Section to a subsequent opinion by this Honorable Court, that the challenged Section approaches the semblance of constitutional validity.

The Appellante Court noted that the standing problems of mature, emancipated and "best interests" minors, present in *H.L.* v. *Matheson,* ____ U.S. ____, 101 S.Ct. 1164, 67 L.Ed.2d 388 (1981), were not present here. (655 F.2d at 858-859). (A-67-A-68).

CONCLUSION

Despite the best efforts of the Appellate Court to rewrite the challenged Section 188.028 under the pretense of statutory construction; its zealous intrusion into legislating can not be condoned. The Missouri General Assembly's ill-timed enactment, weeks before the enlightenment offered by this Honorable Court in *Bellotti, II, supra,* can not be saved by a blurring of the lines delineating the separate branches of government.

The Missouri General Assembly is free to pass appropriate legislation governing minors and abortions, which conports with constitutional requirements. It has failed to do so in this instance and to date.

WHEREFORE, Petitioners pray that a Writ of Certiorari be issued to the Eighth Circuit Court of Appeals, allowing the judgment of that Appellate Court sustaining the constitutionality of Missouri Revised Statutes, §128.082.1 and §128.028.2(1), (3), (4), (5) and (6) to be reversed, and for such further orders as this Honorable Court deems appropriate.

Respectfully submitted,

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Appendix

APPENDIX A

PLANNED PARENTHOOD ASSOCIATION OF
KANSAS CITY, MISSOURI, INC. et al.,
Plaintiffs,

v.

John ASHCROFT et al., Defendants.

No. 79 4142 CV C.

United States District Court,
W. D. Missouri, C. D.

Jan. 23, 1980.

OPINION AND ORDER

ELMO B. HUNTER, District Judge:

This is an action for declaratory and injunctive relief in which plaintiffs challenge the constitutionality of several sections of the 1979 Missouri act relating to the regulation of abortions ("the Act").[1] This Court has jurisdiction under 42 U.S.C. § 1983 and 28 U.S.C. § 1343(3).

Plaintiffs are Planned Parenthood Association of Kansas City, Missouri, Inc., and Reproductive Health Services, not-for-profit Missouri corporations. Plaintiffs maintain and operate out-patient clinics in Kansas City and St. Louis, Missouri, respectively, at which medical services are offered to the public, including first trimester abortions performed by staff physicians and pregnancy-related counseling.

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[1] House Committee Substitute for House Bill Nos. 523, 626 and 902, 80th Gen. Ass'y, 1st Reg.Sess. (1979). The full text of the Act is set out in the Appendix.

Plaintiff physicians are Allen S. Palmer, D. O., and Naim S. Kassar, M. D. Dr. Palmer is licensed to practice medicine in the State of Missouri and performs first trimester abortions on an out-patient basis, both at the Reproductive Health Services clinic and as part of his private medical practice. Dr. Palmer does not perform abortions after the first trimester of pregnancy, but would do so absent the statutory requirement that post-twelve week abortions be performed only in a hospital. Dr. Kassar is also licensed to practice medicine in the State of Missouri. As a part of his medical practice, Dr. Kassar performs first trimester abortions on an out-patient basis in the Planned Parenthood clinic and in a hospital setting. Dr. Kassar performs post-first trimester abortions in a hospital setting but, under certain conditions, would perform such abortions in an out-patient clinic, absent the statutory requirement that post-twelve week abortions be performed only in a hospital.

Defendants are the Honorable John Ashcroft, Attorney General of the State of Missouri, and Ralph L. Martin, Prosecuting Attorney of Jackson County, Missouri, who is sued both in that capacity and "as representative of the class of all similar Prosecuting Attorneys of the various counties of the State of Missouri."

The Act was passed by the General Assembly of the State of Missouri on June 15, 1979, and signed into law by the Governor on June 29, 1979. An emergency clause caused the Act to be effective immediately upon the Governor's approval.[3] This action was filed on June 30, 1979, and after a hearing, the Court temporarily restrained enforcement of §§ 188.020, .025, .030, .039, .040, .052, .063, and .075, RSMo, as signed into law on June 29, 1979. Defendants consented to renewal and extension of that order pending a determination on the merits. Upon defendants' motion and to maintain the status quo, the temporary restraining order was modified on September 27, 1979, to delete §§ 188.020, .025, and .075, RSMo, from its effect. Full trial on the merits was had on October 15-20, 1979.

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[3] *Id.*, § A.

I.

Standing

[1] Plaintiff physicians have standing to challenge the constitutionality of the sections at issue in this case. *Singleton* v. *Wulff,* 428 U.S. 106, 98 S.Ct. 2868, 49 L.Ed.2d 826 (1976). Defendants concede that the corporate plaintiffs have standing to challenge § 188.025, the requirement that post-twelve week abortions be performed only in a hospital, and § 188.063, which regulates abortion counseling in "abortion facilities," but assert that the organizations lack standing to litigate the constitutionality of any other of the Act's provisions. In light of the standing of plaintiff physicians, the Court need not reach the issue of the corporate plaintiffs' standing.[3]

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[3] Defendants contend that, excepting §§ 188.025 and 188.063, the Act imposes no obligation or regulation on clinics which offer abortion services but rather is directed at the regulation of physicians who perform abortions. *But see Womens Services, P.C.* v. *Thone,* 483 F.Supp. 1022 (D.Neb.1979) (abortion clinic has standing based on theory of accessory liability under abortion regulation's criminal sanctions); *Akron Center for Reproductive Health, Inc.,* v. *City of Akron,* 479 F.Supp. 1172 (N.D.Ohio 1979); *Baird* v. *Bellotti,* 393 F.Supp. 847 (D.Mass.1975), *vacated and remanded on other grounds,* 428 U.S. 132, 96 S.Ct. 2857, 49 L.Ed.2d 844 (1976). *See also* § 188.075 RSMo ("Any person who contrary to the provisions of [the Act] knowingly . . . aids in the performance of any abortion . . . shall be guilty of a class A misdemeanor . . . .."); § 562.041, RSMo (general criminal accessory liability statute); § 562.056, RSMo (corporate liability statute).

II.

Abortions to be Performed Only by a Physician

Section 188.020 provides: "No person shall perform or induce an abortion except a physician." Plaintiffs' challenge to this restriction is that it prevents a pregnant woman from inducing or performing an abortion on herself. The constitutional infirmity, argue plaintiffs, is two-fold: (1) the statute violates the pregnant woman's constitutional right to "self-treatment," and (2) the Act's penalty provision[4] mandates accessory criminal liability for the physician who, by prescribing an abortion-inducing medication or other abortifacient for a pregnant woman, would aid or abet a non-physician (the pregnant woman herself) to perform or induce an abortion in violation of § 188.020.[5]

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[4] § 188.075, RSMo.

[5] Plaintiffs' medical experts testified of their use of the so-called "morning-after pill," high dosage estrogen prescribed within 48-72 hours following intercourse. The effect of the morning-after pill is to prevent nidation (implantation of the fertilized ovum in the uterine wall). Because the morning-after pill works *after* conception, it is an abortifacient. Plaintiff physicians testified that although the doctor prescribes and provides the abortifacient medication, it is the pregnant woman who decides whether to take the drug and who administers the medication to herself. In such a situation, say plaintiffs, the doctor assists the pregnant woman to abort herself. Plaintiffs suggest that the same reasoning also applies to use of the intrauterine device (IUD); that the doctor's insertion of an UID aids the woman in aborting herself should conception occur. There was also testimony regarding the development of a new abortifacient in the form of a tampon impregnated with prostaglandins, which could be inserted by the woman and have the effect of self-induced abortion. There was no evidence, however, that this abortifacient is presently availabe.

Defendants argue that because the morning-after pill and, "in nearly all cases," the IUD work prior to development of the embryo, neither constitutes an abortion within the meaning of the Act. However, the

Plaintiffs do not argue that the legislature intended to include the pregnant woman herself within the limitation imposed by the statute but submit that that "plain wording" of the section does so. Accordingly, the prayed-for relief is "merely . . . a declaration that this Section may not constitutionally apply to women seeking to self-abort or to physicians who assist them in doing so."

The context of the present case makes a determination of the constitutional questions posed by plaintiffs unnecessary. The regulation against abortions performed by nonphysicians has been in effect in the State of Missouri, with substantially similar language, since June 14, 1974.[6] This Court is unaware of any case in which the prohibition on abortion by nonphysicians was ever applied to the pregnant woman herself. The Corut has been directed to no decision of the courts of the State of Missouri which interprets the provision in that way. There is nothing in the extensive record in this case which would indicate that the legislature intended to criminalize an act of self-abortion by the pregnant woman herself.[7]

Act defines "abortion" as "the intentional destruction of the life of an embryo or fetus in his or her mother's womb *or* the intentional termination of the pregnancy of a mother with an intention other than to increase the probability of a live birth or to remove a dead or dying unborn child." § 188.015.1, RSMo (emphasis added).

[6] Section 188.020(1), RSMo (Supp.1979) (repealed June 29, 1979; § 188.020 of the 1979 Act was enacted in lieu thereof) provided: "No abortion shall be performed . . . except: (1) By a duly licensed, consenting physician . . . ."

[7] Section 188.080, RSMo, provides:

> Any person who is not a licensed physician as defined in section 188.015 who performs or attempts to perform an abortion *on another* as defined in subdivision (1) of section 188.015, is guilty of a felony . . .. (emphasis added)

This section was enacted as a part of the 1974 act relating to abortion and remained in effect at the time of enactment of the 1979 Act.

[2,3] This Court is obliged to give the regulation that reasonable interpretation which avoids a danger of constitutional invalidity. *United States* v. *Harriss,* 347 U.S. 612, 74 S.Ct. 808, 98 L.Ed. 989 (1954); *State* v. *Metropolitan St. Louis Sewer District,* 365 Mo. 1, 275 S.W.2d 225 (En banc 1955). That reading of the section's prohibition of abortions performed by nonphysicians which would include the pregnant woman herself within its ban raises such a serious constitutional question. Accordingly, it is not adopted by the Court. As applied to a nonphysician performing an abortion *on another person,* the statute is not challenged here and is clearly valid. *Connecticut* v. *Menillo,* 423 U.S. 9, 96 S.Ct. 170, 46 L.Ed.2d 152 (1975).

III.

Post-Twelve Week Abortions to be Performed Only in a Hospital

[4] Section 188.025 provides that every abortion performed subsequent to the first twelve weeks of pregnancy shall be performed in a hospital. Both physician plaintiffs testified that, absent statutory prohibition, they would perform post-twelve weeks abortions in an out-patient clinic. Plaintiff's argue that the in-hospital requirement places an undue burden on the abortion decision and on the means of effectuating that decision. Plaintiffs also contend that the requirement does not constitute a reasonable regulation in the interests of maternal health.

In *Roe* v. *Wade,* 410 U.S. 113, 163, 93 S.Ct. 705, 732, 35 L.Ed.2d 147 (1973), the Supreme Court held that "from and after [approximately the end of the first trimester], a State may regulate the abortion procedure to the extent that the regulation reasonably relates to the preservation and protection of maternal health." An example of a permissible subject of regulation was "the facility in which the procedure is to be performed, that is, whether it must be a hospital or may be a clinic or some other place of less-than-hospital status." In *Doe* v. *Bolton,* 410 U.S.

179, 195, 93 S.Ct. 739, 749, 35 L.Ed.2d 201 (1973), the Court struck down a requirement that all abortions be performed in an accredited hospital but reserved the authority of a state to adopt such a regulation after the first trimester "so long as those standards legitimately related to the objective the State seeks to accomplish."

In *Wynn* v. *Scott,* 449 F.Supp. 1302 (N.D.Ill.), *appeal dismissed sub nom. Carey* v. *Wynn,* 439 U.S. 8, 99 S.Ct. 49, 58 L.Ed.2d 7 (1978), *aff'd,* 599 F.2d 193 (7th Cir. 1979), the district court noted that the Supreme Court "specifically stated" that the state may require post-first trimester abortions be performed only in hospitals. The court upheld as rationally related to maternal health a regulation which required post-first timester abortions be performed on an in-patient basis in a hospital equipped with life-support equipment for the fetus if there is any "clearly visible evidence" of viability. In that case, the court noted, 449 F.Supp. at 1318:

> The methods of performing abortions after the first trimester are relatively complicated. Injection of saline or prostaglandins into the amniotic sac, and hysterotomies take time and require controlled conditions.

Plaintiffs urge that the record before this Court is significantly different from that before the district court in *Wynn;* that the advancement of medical knowledge renders the reasoning of *Wynn* inapplicable.

The controversy over Missouri's in-hospital requirement centers on the abortion technique known as dilatation and evacuation (D & E).[8] This post-first trimester abortion technique was relatively unknown at the time of the 1973 Supreme Court decisions in *Roe* and *Doe* but has come to be a common procedure for the termination of pregnancies of longer than twelve weeks gestation.[9] Plaintiff physicians state that D & E is currently the safest post-first trimester abortion technique up to eighteen weeks gestation and that absent the statutory prohibition they would perform post-first trimester abortions using the D & E method in clinics on an out-patient basis. Plaintiffs' medical experts testified that, consistent with good medical practice, post-first trimester abortions can be done safely in an out-patient clinic, at least up to eighteen weeks gestation. Defendants' experts testified that all post-first trimester abortions, regardless of technique employed, should be performed in a hospital because of the increasing risk accompanying later abortions and the ability of a hospital to better deal with potential complications.[10]

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[8] Plaintiffs concede that post-first trimester abortion techniques other than D & E, including saline instillation, prostaglandins, hysterotomy and hysterectomy, should be performed only in a hospital.

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[9] In 1977, 73.3% of reported abortions at 13-15 weeks gestation were done by D & E. Of all reported post-12 week abortions, 38.6% were done by D & E. Utilizaton of other methods for post-12 week abortions in 1977 was as follows: saline instillation, 38.3%; prostaglandins, 16.5%; hysterotomy, 0.4%; hysterectomy, 0.5%; other and unknown, 5.6%. Center for Disease Control, U.S.Dep't of H.E.W. *Abortion Surveillance 1977*, Table 18.

[10] Defendants' experts testified that a hospital would be equipped with life support systems, an intensive care unit, and a blood bank, and would have the services of an expert anesthesiologist, all of which would be unavailable at a free-standing out-patient clinic. Plaintiffs argue that the emergency room resources of nearby hospitals would be available in case of complications resulting from abortions performed at out-patient clinics.

In *Planned Parenthood* v. *Danforth,* 428 U.S. 52, 96 S.Ct. 2831, 49 L.Ed.2d 788 (1976), the Supreme Court held that a Missouri statutory prohibition on the use of saline instiilation as a post-twelve abortion technique failed as a reasonable regulation for the protection of maternal health.

> The State, . . . would prohibit the use of a method which the record shows is the one most commonly used nationally by physicians after the first trimester and which is safer, with respect to maternal mortality, than even continuation of the pregnancy until normal childbirth. Moreover, as a practical matter, it forces a woman and her physician to terminate her pregnancy by methods more dangerous to her health than the method outlawed.

Id., at 78-79, 96 S.Ct. at 2845. The court found that the *existence* of prostaglandins instillation, an alternative technique actually safer than saline, did not justify the ban on saline. The prostaglandins alternative was at that time limited to experimental use and, as a practical matter, was unavailable in the State of Missouri.[11] The prohibition of the saline technique was therefore "an unreasonable or arbitrary regulation designed to inhibit, and having the effect of inhibiting, the vest majority of abortions after the first twelve weeks." *Id.,* at 79, 96 S.Ct. at 2845.

On the record before it, this Court is convinced that aside from the question whether it is performed in a hospital or in an out-patient clinic,[12] dilatation and evacuation is the safest of the presently available post-twelve week abortion techniques.[13] However, the record also indicates that post-twelve week D & E procedures are performed at only one hospital in the State of Missouri.[14] Thus, the requirement that all post-twelve week abortions be performed in a hospital has the practical effect of making a D & E procedure, the safest post-twelve week technique, an alternative which is simply unavailable to many pregnant women in Missouri. Under the reasonaing of the Supreme Court in *Danforth,* the state's limitation of post-twelve week abortions to hospitals cannot stand as a reasonable regulation for the protection of maternal health. The effect of the regulation is to make unavailable the most commonly utilized and the safest post-twelve week abortion technique. As a practical matter, it may force a woman and her doctor to terminate her pregnancy by a method made unavailable. The limited availability of the D & E procedure in a single hospital on the western boundary of the state does not convince the Court that D & E is an accessible or meaningful alternative to large numbers of pregnant women in Missouri, particularly those in rural areas or in the metropolitan St. Louis area on Missouri's eastern border. *See Planned Parenthood* v. *Danforth, supra,* 428 U.S. at 77 n. 12, 96 S.Ct. 2831.

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[11]. "Such an experimental and limited use of prostaglandin throughout the country does not make it available or accessible to concerned persons in Missouri." *Planned Parenthood* v. *Danforth, supra,* at 77 n.12, 96 S.Ct. at 2845.

[12]. Dr. Bernard Nathanson, one of defendants' experts, testified that the morality and morbidity rates for D & E procedures performed outside a hospital were probably no different than those performed in a hospital.

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[13]. Mortality rates (per 100,000 cases) for post-12 week abortion techniques for the years 1972-1977 are as follows:

D & E	8.3
Prostaglandins and other agents	10.8
Saline instillation	15.5
Hysterotomy and hysterectomy	45.3

Center for Disease Control, U.S.Dep't of H.E.W., *Abortion Surveillance 1977,* Table 23.

[14]. The uncontroverted testimony of Dr. Naim Kassar was that the Truman Medical Center in Kansas City is the only hospital in the State of Missouri which permits post-12 week abortions by D & E. *Cf. Poelker* v. *Doe,* 432 U.S. 519, 97 S.Ct. 2391, 53 L.Ed.2d 528 (1977)(a state or city may constitutionally close public hospitals to *all* nontherapeutic abortions).

Missouri's in-hospital requirement for all post-twelve week abortions fails for another reason. In *Planned Parenthood* v. *Danforth*, the Supreme Court held that the state may not grant a third party, in that case the parents of an unmarried woman under the age of eighteen, an absolute veto over the decision ;of the physician and his patient to terminate the patient's pregnancy. 428 U.S. at 74-75, 96 S.Ct. 2831. *See also Bellotti* v. *Baird (Bellotti II)*, 443 U.S. 622, 639, 99 S.Ct. 3035, 3046, 61 L.Ed.2d 797, 818 (1979). The record before this Court indicates taht there is no hospital in the State of Missouri which will admit a woman under the age of eighteen without parental consent.[15] The statute's effect is to impose an absolute parental consent requirement for women under the age of eighteen who desire to terminate pregnancies of longer than twelve weeks gestation. The in-hospital requirement gives the parents of a woman under eighteen who desires a post-twelve week abortion the "absolute, and possibly arbitrary, veto" outlawed by the Supreme Court in *Danforth* and therefore cannot stand.[16]

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[15]. Uncontroverted testimony of Drs. Allen Palmer, Naim Kassar, and Robert Crist. There was evidence that a high proportion of women desiring post-12 week abortions are in the younger age group. Reasons for delay in seeking an abortion by women under 18 include a lack of sophistication, psychological denial by the younger woman of the fact of her pregnancy, a concern for privacy, and a lack of knowledge and the means to seek an earlier abortion.

[16]. It may be argued that this infirmity is avoided by the provision in § 188.028 for judicial consent or judicially-granted self-consent to an abortion for a woman under 18. Even if that procedure was constitutionally valid, *see* Part IV, *infra*, it does not provide for judicial consent to hospitalization of a woman under 18 or that Missouri hospitals must alter their admissions policies to accept either judicial consent or judicially-granted self-consent and admit women under 18 without parental consent.

Plaintiffs additionally argued: (1) that the increased cost, longer time required, and loss of anonymity associated with an in-hospital

IV.

Consent for Minors

[5] Section 188.028 provides a special procedure to obtain or provide consent for an abortion in the case of a pregnant woman as under the age of eighteen. Unless a minor is "emancipated," in order for her to obtain an abortion she must secure the consent of one parent or guardian, she must have been granted by court order the right to self-consent, or she must have been granted judicial consent to the abortion. The statute sets out a procedure whereby the minor may seek either the right to self-consent or judicial consent. It provides for the filing of an application in the juvenile court by the minor or her next friend and specifies necessary allegations, including the intitials of the minor and the names and addresses of her parents, guardian, or person standing in loco parentis. The minor's parents, guardian or person standing in loco parentis are then to be served with copies of the petition and notice of the time and place of the hearing on the minor's application. There is provision for constructive notice by certified mail if service is not had within two days. The Court may appoint a guardian ad litem for the minor if a conflict of interests appears between the child and her parents or guardian. There is provision for the appointment of counsel, in appropriate circumstances, for "any party."

A hearing is to be held within five days of the filing of the petition, at which the court is to hear evidence relating to whether the minor should be granted the right to self-consent to an abortion or whether the abortion is in her best interest. The court is then to issue a decree in which it shall, for good cause, take one of the following actions: (1) grant the minor the right

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post-12 week abortion constitutes an undue burden on the effectuation of a pregnant woman's abortion decision; and (2) that the in-hospital requirement is actually contrary to the promotion of maternal health due to an increased risk of infection and the prevalent use of general anesthetics in most hospitals. In light of the above, it is not necessary to reach these arguments.

to self-consent; (2) find the abortion to be in the best interests of the minor and grant judicial consent, setting forth grounds for so finding; or (3) deny the minor's petition, setting forth grounds on which it was denied. Either the minor or her parents or guardian may appeal from such an order to the Missouri Court of Appeals by giving notice of intent to appeal within twenty-four hours from issuance of the order. The appeal must be perfected within five days of the filing of such notice. The section provides that the Missouri Supreme Court shall, by court rule, provide for expedited appellate review of such cases. Plaintiffs challenge the validity of the consent procedure for minors on the ground that it permits the juvenile court to deny a minor access to an abortion even though she may be sufficiently mature and competent to make the abortion decision on her own.[17]

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[17]. Plaintiffs' attack on this section was not limited to a single issue. They also argued that the section is unconstitutional because (1) it mandates parental involvement in all cases, contrary to *Bellotti II, supra* (plurality opinion of Powell, J.), *see Charles* v. *Carey,* No. 79 C 454 (N.D.Ill. preliminary injunction filed Nov. 16, 1979); *Women's Community Health Center, Inc.* v. *Cohen,* 477 F.Supp. 542 (D.Me.1979); *Woman's Services, P.C.* v. *Thone,* — F.Supp. — (D.Neb. partial summary judgment filed Aug. 1, 1979); *Leigh* v. *Olson,* No. A3-79-78 (D.N.D. preliminary injunction filed July 9, 1979); (2) it creates an unjustified distinction between two classes of minors, those who consent to carry a pregnancy to term and undergo normal delivery or Caesarian section and those who consent to have an abortion, contrary to the holding in *Wynn* v. *Carey,* 582 F.2d 1375 (7th Cir. 1978); (3) the alternative judicial proceeding constitutes an undue burden on the abortion decision, *see Wynn* v. *Carey, supra;* (4) the statute is unconstitutionally vague because the term "emancipated" is not defined; and (5) that the judicial proceeding outlined in the sectin does not assure the "anonymity and sufficient expedition" required in *Bellotti II, supra,* (plurality opinion of Powell, J.), because it simply authorizes the future promulgation of rules to expedite appellate review in such cases. It is unnecessary to reach these arguments.

In *Planned Parenthood* v. *Danforth, supra,* the Supreme Court struck down a requirement that unmarried minors obtain the consent of a parent or person in loco parentis.

> [T]he State does not have the constitutional authority to give a third party an absolute, and possibly arbitrary, veto over the decision of the physician and his patient to terminate the patient's pregnancy regardless of the reason for withholding the consent.

428 U.S. at 74, 96 S.Ct. at 2843. The Court further defined the constitutional limitations in this area in *Bellotti* v. *Baird (Bellotti II),* 443 U.S. 622, 99 S.Ct. 3035, 61 L.Ed.2d 797 (1979), in which it concluded:

> [I]f the State decides to require a pregnant minor to obtain one or both parent's consent to an abortion, it also must provide an alternative procedure whereby authorization for the abortion can be obtained.

443 U.S. at 643, 99 S.Ct. at 3048, 61 L.Ed.2d at 813 (plurality opinion of Powell, J.). In *Bellotti II* the Court considerea a Massachusetts consent for minors statute which provided:

> If the mother is less than eighteen years of age and has not married, the consent of both the mother and her parents [to an abortion to be performed on the mother] is required. If one or both of the mother's parents refuse such consent, consent may be obtained by order of a judge of the superior court for good cause shown, after such hearing as he deems necessary.

443 U.S. at 625, 99 S.Ct. at 3039, 61 L.Ed.2d at 802. Because the statute was susceptible of a construction which might sustain its validity, the Supreme Court initially abstained so that the courts of Massachusetts might provide a conclusive interpretation. *Bellotti* v. *Baird (Bellotti I),* 428 U.S. 132, 96 S.Ct. 2857, 49 L.Ed.2d 844 (1976). The Supreme Judicial Court of Massachusetts interpreted the statute to authorize the court to

refuse its consent if it determined that an abortion would not be in the best interests of the minor, even though the minor might be capable of making an informed and reasonable decision herself. 443 U.S. at 650, 99 S.Ct. at 3051-52, 61 L.Ed.2d at 817-18. The Supreme Court found the Massachusetts statute, as interpreted, constitutionally invalid.

> [I]f the minor satisfies a court that she has attained sufficient maturity to make a fully informed decision, she then is entitled to make her abortion decision independently. We therefore agree with the District Court that [the statute] cannot constitutionally permit judicial disregard of the abortion decision of a minor who has been determined to be mature and fully competent to assess the implications of the choice she has made.

443 U.S. at 650, 99 S.Ct. at 3052, 61 L.Ed.2d at 818 (plurality opinion of Powell, J.).[18]

443 U.S. at 654, 99 S.CT. at 3053, 61 L.Ed.2d at 820 (concurring opinion of Stevens, J.).

Section 188.028.2(4) of the Missouri Act requires the juvenile court determine the issue of consent in one of three ways.

> (4) In the decree, the court shall for good cause:
>
> (a) Grant the petition for majority rights for the purpose of consenting to the abortion; or
>
> (b) Find the abortion to be in the best interests of the minor and give judicial consent to the abortion, setting forth the grounds for so finding; or

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[18] [The Massachusetts statute] does, of course, provide an alternative in the form of a suit initiated by the woman in Superior Court. But in that proceeding, the judge is afforded an absolute veto over the minor's decisions, based on his judgment of her best interests.

> (c) Deny the petition, setting forth the grounds on which the petition is denied;

. . . . .

Defendants contend that the court may deny the petition "provided that it finds that the minor is not mature, and that an abortion would not be in her best interest." Defendants' Post-trial Brief at 26. This procedure cures the defect in *Bellotti II*, say defendants, "because there is no opportunity for judicial authorization for an abortion to be withheld where a minor is found to be mature and competent to make the decision independently . . . ." *Id.*, at 27.

This Court is unable to subscribe to defendants' reading of the statute. Although the juvenile court is authorized to select one of three alternatives, each of the three is clearly independent of the others, connected in the statute with the disjunctive "or." Alternative (c) permits the court to "deny the petition," guided only by the general standard that such action be "for good cause." Defendants suggest that the legislative intent is clear that the juvenile court may deny the minor's petition *only* if it finds that an abortion is not in the best interests of the minor *and* that the minor is not competent to decide for herself. Such an intent is not evident in the statute nor was any such showing made at trial. It is clear to this Court that alternative (c) authorizes the juvenile court to deny the minor's petition for good cause, but does not require a prior finding that the minor is not sufficiently mature and not competent to make a decision regarding abortion independently.

Defendants alternatively request that the Court abstain from ruling, citing *Bellotti I*. In that case the Supreme Court said that abstention is appropriate if an unconstrued state statute is susceptible to a construction which might avoid the need for federal constitutional adjudication,"[19] 428 U.S. at 146-47, 96 S.Ct. 2857, and found that particular statute susceptible to such a construction. It is clear to this Court that section 188.028 is not susceptible to a reasonable construction which would avoid the federal constitutional question controlling in *Bellotti II*. The statute permits the juvenile court to deny the minor's application but does not require that the court first find the minor not competent to make a decision independently. Accordingly, the Court declines to abstain.

The consent procedure in section 188.028 permits judicial authorization for an abortion to be withheld from a minor who is sufficiently mature and competent to make a decision regarding abortion independently, contrary to the ruling in *Bellotti II*. It creates the absolute veto proscribed in *Danforth* and, under that case and *Bellotti II*, is unconstitutional. *Scheinberg* v. *Smith*, 482 F.Supp. 529 (S.D.Fla.1979) (see memorandum opinion accompanying preliminary injunction filed July 13, 1979, *sub nom. Jones* v. *Smith*); *Akron Center for Reproductive Health, Inc.* v. *City of Akron*, 479 F.Supp. 1172 (N.D.Ohio 1979).

V.

Abortion After Viability

[6] Section 188.030 regulates abortion in cases in which the fetus has reached viability. In three subsections, the statute prescribes when post-viability abortions may be performed, regulates the abortion technique to be employed, and requires the attendance of a second physician and a specified standard of care. Each subsection will be discussed in turn.

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[19]. The Court noted that the rule of the Supreme Judicial Court of Massachusetts which permits certification of questions directly to that court for prompt resolution "greatly simplifie[d]" the Court's analysis. There is no such procedure in Missouri.

Defendants initially contend that no plaintiff has standing to challenge any part of seciton 188.030 because no plaintiff presently performs or desires to perform abortions past the stage at which the fetus if viable. Plaintiff Dr. Naim Kassar testifed that, in the interests of maternal health, he has performed an abortion as late as approximately twenty-eight weeks gestation. Although the Supreme Court stated that it is not the function of either the legislature or the courts to place viability at a specific point in the gestation period, *Danforth, supra,* 428 U.S. at 64, 96 S.Ct. 2831, the Court noticed in *Roe* that viability usually had been placed at about twenty-eight weeks, but could occur as early as twenty-four weeks. *Roe, supra,* 410 U.S. at 160 93 S.Ct. 705. Enforcement of section 188.030 would have an immediate and direct effect on the medical practice of Dr. Kassar; he therefore has standing to contest its constitutional validity.

Subsection 1 provides that "[n]o abortion of a viable unborn child shall be performed unless necessary to preserve the life or health of the woman" and requires the physician certify in writing that such an abortion is necessary to preserve the life or health of the woman, the medical indications for the abortion, and the probable health consequences. The Act's penalty section mandates criminal liability for "[a]ny person who contrary to the provisions of [the Act] knowingly performs . . any abortion . . .." Plaintiffs argue that subsection 1, in conjunction with imposition of criminal liability, is unconstitutionally vague because it sets no standards regarding the determination of viability by the physician. Plaintiffs further argue that the subsection is unconstitutional because it would impose strict criminal liability on a physician for an erroneous, but good faith, determination of fetal nonviability.

In *Colautti* v. *Franklin,* 439 U.S. 379, 99 S.Ct. 675, 58 L.Ed.2d 596 (1979) the Supreme Court ruled on a Pennsylvania statute which provided that "[e]very person who performs or induces an abortion shall prior thereto have made a determination based on his experience, judgment or professional competence that the fetus is not viable, and if the determination is that the fetus is viable or if there is sufficient reason to believe that the fetus may be viable," that the physician exercise a specified standard of care. Plaintiffs in that case argued that the viability determination requirement was unconstitutionally vague because it failed to inform the physician when his duty to the fetus arose and because it did not make the physician's good faith determination of viability conclusive.

The Court held the Pennsylvania viability determination requirement void for vagueness because of a "double ambiguity." The statute set no clear standard regarding the doctor's determination of fetal viability; whether it was to be a purely subjective determination or whether the physician was subject to a mixed subjective and objective standard.

> In other words, it is ambiguous whether there must be "sufficient reason" from the perspective of the judgment, skill, and training of the attending physician, or "sufficient reason" from the perspective of a cross-section of the medical community or a panel of experts. The latter, obviously portends not an inconsequential hazard for the typical private practitioner who may not have the skills and technology that are readily available at a teaching hospital or large medical center.

Id., 439 U.S. at 391, 99 S.Ct. at 683, 58 L.Ed.2d at 606-07. Inclusion of the phrase "may be viable" injected a second ambiguity: whether the statute delineated some new time period in a pregnancy during which there might be a remote possibility of viability somewhere short of "viability" itself.

Compounding the vagueness of the statute, said the Court, was the fact that it "subjects the physician to potential criminal liability, without regard to fault." Although the criminal penalty provision did require scienter *with respect to the act of abortion,* there was no requirement of a culpable mental state *regar-*

ding the doctor's determination that the fetus is or "may be" viable.[20]

> Because of the absence of a scienter requirement in the provision directing the physician to determine whether the fetus is or may be viable, the statute is little more than "a trap for those who act in good faith." [citation omitted]

The perils of strict criminal liability are particularly acute here because of the uncertainty of the viability determination itself. As the record in this case indicates, a physician determines whether or not a fetus is viable after considering a number of variables: the gestational age of the fetus, derived from the reported menstrual history of the woman; fetal weight, based on an inexact estimate of the size and condition of the uterus; the woman's general health and nutrition; the quality of the available medical facilities; and other factors. Because of the number and the imprecision of these variables, the probability of any particular fetus' obtaining meaningful life outside the womb can be determined only with difficulty. Moreover, the record indicates that even if agreement may be reached on the probability of survival, different physicians equate viability with different probabilities of survival, and some physicians refuse to equate viability with any numerical probability at all. In the face of these uncertainties, it is not unlikely that experts will disagree over whether a particular fetus in the second trimester has advanced to the stage of viability. The prospect of such disagree-

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[20] The Court noted that the statute did provide a subjective standard for the determination of viability, and that it was ambiguous whether that standard also applied to the determination that the fetus "may be viable." However, the application of a subjective standard did not avoid the strict criminal liability issue. "A subjective standard keyed to the physician's individual skill and abilities, however, is different from a requirement that the physician be culpable or blameworthy for his performance under such a standard." *Collautti* v. *Franklin,* 439 U.S. at 395, 99 S.Ct. at 685, 58 L.Ed.2d at 609 n. 12.

> ment, in conjunction with a statute imposing strict civil and criminal liability for an erroneous determination of viability, could have a profound chilling effect on the willingness of physicians to perform abortions near the point of viability in the manner indicated by their best medical judgment.

Id., 439 U.S. at 395, 99 S.Ct. at 685, 58 L.Ed.2d at 609-10. However, because the viability determination requirement was "void on its face," the Court in *Colautti* declined to decide in that case "whether, under a properly drafted statute, a finding of bad faith or some other type of scienter would be required before a physician could be held criminally responsible for an erroneous determination of viability."

The Missouri regulation prohibits the abortion of a viable fetus, with the exception of necessity to preserve the life or health of the woman, and subjects the physician to criminal liability for its violation. Although the penalty provision requires a culpable mental state, "knowingly," regarding the act of abortion, neither the penalty section nor the substantive prohibition contains a culpable mental state requirement regarding the attending physician's necessary determination of fetal viability or nonviability. By its own terms, the statute is absolute. The physician who performs an abortion based on his good faith determination, in the exercise of his best medical judgment, that the fetus is not viable is subject to strict criminal liability if his determination is erroneous, regardless of his state of mind. Thus, the question deferred by the Supreme Court in *Colautti* is presented to this Court.

The record in this case relating to the determination of viability parallels that described by the Court in *Colautti*. The determination by the attending physician whether any particular pregnancy has passed the point of fetal viability is based on a number of variables, none of which is susceptible of precise determination, and is uncertain at best. Further, there is a difference of medical opinion regarding the probability of survival necessary before a fetus may be considered "viable."

The Supreme Court affirmed in *Danforth* that viability is a medical concept involving the judgment of the attending physician and his skill and technical ability, and by its nature is flexible and imprecise, varying with each pregnancy. It is clear to this Court that strict criminal liablity attending upon an erroneous determination by a physician that a particular pregnancy had not yet reached the point of viability not only offends due process[21] but denies the attending physician presented with a woman whose pregnancy is close to the point of viability "the room he needs to make his best medical judgment." *Doe* v. *Bolton,* 410 U.S. at 192, 93 S.Ct. at 747; *Colautti* v. *Franklin, supra.*[22] Accordingly, the regulation in subsection 1, which incorporates strict criminal liability for an erroneous determination of viability, cannot stand.

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[21] *See Morissette* v. *United States,* 342 U.S. 246, 250, 72 S.Ct. 240, 243, 96 L.Ed. 288 (1952):

> The contention that an injury can amount to a crime only when inflicted by intention is no provincial or transient notion. It is as universal and persistent in mature systems of law as belief in freedom of human will and a consequent ability and duty of the normal individual to choose between good and evil.

In *Holdridge* v. *United States,* 282 F.2d 302, 310 (8th Cir. 1960), then Judge, now Justice, Blackmun described the type of offense in which the absence of a culpable mental state would not offend due process:

> [W]here it seems to involve what is basically a matter of policy, where the standard imposed is, under the circumstances, reasonable and adherence thereto properly expected of a person, where the penalty is relatively small, where conviction does not gravely besmirch . . ..

The penalty provision of the Missouri Abortion Act, § 188.075, RSMo, provides that a violator is guilty of a class A misdemeanor which is punishable by a term of imprisonment not to exceed one year, § 558.011.1(5), RSMo, and a fine not exceeding $5,000, § 560.021.1(2).

[22] The Supreme Court also noted in *Colautti* that strict criminal liability could have "a profound chilling effect on the willingness of physicians to perform abortions near the point of viability in the manner indicated by their best medical judgment."

[7] Subsection 2 of § 188.030 requires that a physician performing an abortion past the point of viability utilize the abortion technique "most likely to preserve the life and health of the unborn child." The subsection further provides that the physician "may" employ some other abortion technique in cases

> where the method of technique of abortion which would most likely preserve the life and health of a the unborn child *would present a greater risk* to the life and health of the woman than another available method or technique. (emphasis added)

The subsection goes on to require in such cases that the performing physician certify in writing the techniques considered and the reasons for choosing the technique actually employed. Plaintiffs argue that subsection 2 is defective for the same reasons as is subsection 1; that it is unconstitutionally vague and that it subjects the physician to criminal liablity without a culpable mental state.

The requirements of the subsection are triggered initially by the physician's determination of fetal viability. The physician is then called upon to determine which abortion technique is "most likely to preserve the life and health" of the fetus. The physician also must decide whether that technique mandated by the statute presents a "greater risk to the life and health of the woman" than some other abortion technique. These medical decisions and others of the same nature are a fundamental part of the daily practice of medical doctors; they have been and will be made every day, completely aside from this statutory requirement. Because of the nature of the science and art of medical practice, these determinations are often uncertain and difficult to make. Experts may, and often do, disagree on their resolution, both in specific cases and as general propositions.[23]

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[23] This record contains conflicting testimony from medical experts regarding the relative safety to the woman and to the fetus of various post-first trimester abortion techniques.

Through the penalty provision, subsection 2 imposes strict liability for an error in *any* of the above medical decisions, regardless of the physician's state of mind. For the reasons discussed in relation to subsection 1, the Court also finds subsection 2 to be constitutionally deficient. *See Colautti* v. *Franklin, supra.*

[8,9] Subsection 2 also suffers from the vagueness fatal to the Pennsylvania statute considered by the Supreme Court in *Colautti.* Although the first sentence of subsection 2 mandates utilization of the abortion technique most favorable to the life and health of the fetus, the second sentence informs the doctor that he "may" use another technique, if that prescribed in the first sentence presents "a greater risk to the life and health of the woman" than some other technique. In this case, and as noted by the Supreme Court in *Colautti,* 439 U.S. at 400, 99 S.Ct. at 688, 58 L.Ed.2d at 612:

> it is uncertain whether the statute permits the physician to consider his duty to the patient to be paramount to his duty to the fetus, or whether it requires the physician to make a "trade-off" between the woman's health and additional percentage points of fetal survival. Serious ethical and constitutional difficulties, that we do not address, lurk behind this ambiguity. We hold only that where conflicting duties of this magnitude are involved, the State, at the least, must proceed with greater precision before it may subject a physician to possible criminal sanctions.

Testimony of Drs. Allen Palmer, Naim Kassar, Robert Crist, and Bernard Nathanson. *See Colautti* v. *Franklin,* 439 U.S. at 401, 99 S.Ct. at 688, 58 L.Ed.2d at 612: "The choice of an appropriate abortion technique, as the record in this case so amply demonstrates, is a complex medical judgment about which experts can—and do—disagree."

The difficulties noted by the Supreme Court are present in subsection 2. The lack of a culpable mental state requirement compounds the uncertainty. *Colautti* v. *Franklin, supra.*[24]

[10] Subsection 3 requires the attendance of a second physician at any abortion performed past the point of viability, "who shall take control of and provide immediate medical care for a child born as a result of the abortion." It also prescribes a standard of care to be exercised by both physicians:

> [They] shall take all reasonable steps in keeping with good medical practice, consistent with the procedure used, to preserve the life and health of the viable unborn child; provided that it does not pose an increased risk to the life or health of the woman.

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[24] Defendants contend that the intent of the subsection is clearly not to require that the life of the fetus be favored over the life of the mother, and alternatively urge abstention in favor of a construction of the provision by the courts of Missouri should this Court find otherwise, citing *Bellotti I.* The judge-made doctrine of abstention, *see Railroad Commission* v. *Pullman Co.*, 312 U.S. 496, 61 S.Ct. 643, 85 L.Ed. 971 (1941), is appropriate in a case in which a challenged state statute is susceptible to a construction by the state judiciary that would avoid or modify the necessity of reaching a federal constitutional question. *Zwickler* v. *Koota,* 389 U.S. 241, 88 S.Ct. 391, 19 L.Ed.2d 444 (1967). On the other hand, if it cannot be fairly concluded that the statute can be reasonably construed so as to avoid the necessity for federal constitutional adjudication, abstention is inappropriate and would amount to a shirking of the responsibilities of the federal courts. *Kusper* v. *Pontikes,* 414 U.S. 51, 94 S.Ct. 303, 38 L.Ed.2d 260 (1973). Because subsection 2 of § 188.030 is defective due to the absence of a culpable mental state requirement, the Court is not convinced that resolution of the vagueness issue, *i. e.,* whether the duty of the physician to his female patient is paramount to the physician's duty to preserve the life and health of the fetus, by a definitive interpretation of the subsection by the Missouri courts would avoid eventual federal constitutional adjudication. The court again notes that there is no procedure to certify questions for prompt resolution to the Missouri Supreme Court. *See Bellotti I,* 428 U.S. at 150-51, 96 S.Ct. 2857.

As with the two previous subsections, the Act's penalty provision imposes criminal liability on the physician who performs an abortion in violation of the regulation due to an erroneous determination of nonviability, without regard to the doctor's mental state. For the reasons discussed above, the Court finds this imposition of strict criminal liability with regard to a medical judgment unconstitutional.

[11,12] The requirement of a second physician is also overbroad. The record shows that dilatation and evacuation may be the procedure of choice, even after viability, in cases in which there are positive contraindications to use of saline or prostaglandins instillation.[25] The experts agreed that D & E carries no chance of fetal survival. The Supreme Court has held that legislative enactments in this area involving fundamental rights "must be narrowly drawn to express only the legitimate state interests at stake." *Roe* v. *Wade,* 410 U.S. at 155, 93 S.Ct. at 728; *Carey* v. *Population Services International,* 431 U.S. 678, 97 S.Ct. 2010, 52 L.Ed.2d 675 (1977). The state has an important and legitimate interest in potential life and may regulate abortion after viability to preserve the life and health of the fetus. *Roe* v. *Wade, supra.* Although the presence of a second physician to care for the child born as a result of a post-viability abortion certainly may further the state's interest in the protection of potential life, the attendance of a second physician during an abortion procedure which holds no possibility of fetal survival does not further that interest. The two-physician regulation is therefore overboard and invalid on that basis.

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[25] Testimony of Drs. Robert Crist (for plaintiffs) and Richard Schmidt (for defendants).

VI.

Informed Consent

[13] Section 188.039 prescribes a procedure to be followed by the woman's physician to secure and document her informed consent to the abortion. The physician must certify: (1) that he informed the woman of the information specified in the statute not less than forty-eight hours prior to her giving her consent to the abortion; (2) if the woman is a minor, that he also provided her parent, legal guardian, or person standing in loco parentis the same information; and (3) the woman's age, based on "proof of age" provided by her. The woman must sign a consent form to acknowledge that she has been informed by the attending physician of the following:

> (1) That according to the best medical judgment of her attending physician she is pregnant;
>
> (2) The number of weeks elapsed from the probable time of conception of her unborn child, based upon the information provided by her as to the time of her last menstrual period and after a history and physical examination and appropriate laboratory tests;
>
> (3) The probable anatomical and physiological characteristics of the unborn child at the time the abortion is to be performed;
>
> (4) The immediate and long-term physical dangers of abortion and psychological trauma resulting from abortion and any increased incidence of premature births, tubal pregnancies and still births following abortion;
>
> (5) The particular risks associated with the abortion technique to be used;
>
> (6) Alternatives to abortion shall be given by the attending physician, including a list of public and private agencies

and services that will assist her during her pregnancy and after the birth of her child.

The section further provides that the physician may inform the woman of "other material facts or opinions" which may be necessary to allow the woman to be fully informed of the nature and consequences of an abortion.

Plaintiffs contend that the section's requirement that the information be given by the attending physician, rather than some other person, is unduly burdensome. At the clinic of plaintiff Reproductive Health Services, information relating to the woman's informed consent to an abortion, including much of the information required by the statute, is presented through an "informed consent" videotape of a doctor discussing the abortion procedure and through sessions with lay counselors, and does not come directly from the physician who actually performs the abortion procedure. Plaintiffs claim that this system was devised as the most efficient and economical method of delivery of this particular medical service and that it would be disrupted if the attending physician had to spend more time with each patient than is presently the practice, thereby increasing the cost of each procedure.[26] An effect of the requirement

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[26] Testimony of Judith Widdicombe, R. N., Executive Director of Reproductive Health Services. Ms. Widdicombe estimated that the cost per procedure would incrase by $70 if the attending physician were required to spend an additional 30 minutes with each patient.

Plaintiffs also argue that this requirement, in conjunction with the 48 hour waiting period, could result in delays of substantially more than 48 hours. Physicians perform abortions at Reproductive Health Services' clinic on a part-time basis, perhaps one afternoon per week. If the physician must give information to each patient on whom he performs an abortion 48 hours prior the procedure, say plaintiffs, delays of one week or more would result, simply because the doctor would not be present at the clinic for at least a week after the initial session with the patient. Plaintiffs argue that the patient's personal schedule might delay the procedure even longer if she could not arrange to come to the clinic on the day on which the physician who presented the information to her was in attendance. The Court notes will be that the doctor who performs the abortion may have to spend more time with each patient than is currently the practice in plaintiffs' clinics. This may result in increased costs, although the additional expense to the patient will certainly depend on the amount of information required to be presented directly by the physician and the actual time required by a particular physician to convey it. On this record, the Court is not convinced that the requirement that information important to the woman's decision to have an abortion come directly from the attending physician is an undue burden on her decision to abort or her obtaining an abortion.[27] The Supreme Court has emphasized the participation and responsibility of the woman's physician regarding the decision to have an abortion and has noted the legitimacy of the state's interest that she make the decision with full knowledge of its nature and consequences. *Planned Parenthood* v. *Danforth, supra.* A requirement that the attending physician personally provide information regarding the abortion decision furthers that interest and is not unconstitutional.[28]

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that plaintiffs have made a showing that the combination of a mandatory waiting period with the requirement that certain information be conveyed by the physician who actually performs the abortion would present a practical problem to plaintiffs' clinics, one result of which could be significant delay between the woman's initial visit and the abortion itself. The 48 hour waiting period has been stricken as an unconstitutional burden on obtaining an abortion.

[27] Testimony regarding the time necessary for a physician to present *all* of the information specified in the statute ranged from 15 minutes to an hour and a half. Some items specified in the section have been stricken as unconstitutional.

It is conceivable that a regulation might require a presentation by the attending physician so lengthy as to become unduly burdensome, although such a finding is not supported by this record.

[28] *See Akron Center for Reproductive Health, Inc.* v. *City of Akron,* 479 F.Supp. 1172 (N.D. Ohio 1979); *Women's Community Health Center, Inc.* v. *Cohen,* 477 F.Supp. 542 (D.Me.1979).

[14] Plaintiffs challenge the forty-eight hour waiting period as an undue burden on the abortion decision which actually increses the risk to the woman's health. The experts seem to be in accord that the length of gestation at the time of abortion is directly related to the risk presented by the procedure to the woman's life and health, the risk increasing the later an abortion is performed.[29] The Court is convinced that the forty-eight hour delay imposed by the statute would have, in the words of plaintiffs' expert, a "significant health impact" on a woman seeking an abortion.[30] There was additional testimony that a mandatory forty-eight hour waiting period could have the effect of a much longer delay due to the nature of physicians' working schedules.[31] The record shows that such delay has a disproportionate impact on minors, who generally seek abortions at a later stage of pregnancy.[32]

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[29] Within the first 12 weeks, the main risk to a woman who wants an abortion results from delay.

> . . . . .
>
> Our findings clearly demonstrate that *any* delay increases the risk of complications to a pregnant woman who wishes an abortion. (emphasis in original)

Willard Cates, Jr., et al., *The Effect of Delay and Method Choice on the Risk of Abortion Morbidity,* 9 Family Planning Perspectives 266, 267-68 (1977) (reprinted by Public Health Service, U.S. Dep't of H.E.W.)

[30] Testimony of Dr. Robert Crist.

[31] Testimony of Drs. Allen Palmer and Robert Kretzschmar. *See* note 26, *supra.*

[32] Testimony of Drs. Enrique Vera, Robert Kretzschmar, Grace Ketterman, and Dr. Elizabeth Smith. *See* note 15, *supra.*

Defendants argue that the waiting period is designed to ensure that the abortion decision is made with "adequate reflection and consideration," and as such furthers the state's interest in maternal health. However, there was expert testimony at trial which indicated that, as a general proposition, women seeking abortions have completely thought out the abortion decision prior to approaching a clinic or personal doctor.[33]

The forty-eight hour waiting period requires that a woman make a minimum of two visits to her physician or to a clinic. This requirement involves additional time and expense and, for women living outside the metropolitan areas, may require additional travel or subsistence expense during the delay.

This Court concludes that the mandatory forty-eight hour waiting period has, in fact, a detrimental effect on the health interests of women seeking abortions and therefore lacks a rational relation with any legitimate state interest. Moreover, the mandatory waiting period is unduly burdensome to women seeking abortions. *Bellotti I, supra.* For both reasons, the mandatory forty-eight hour waiting period is unconstitutional.[34]

[15] Plaintiffs claim that the requirement that the physician certify the woman's age based upon "proof of age offered by her" is void for vagueness. The Court cannot agree. A physician's good faith certification of a woman's age based on as lit-

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[33] Testimony of Dr. Enrique Vera.

[34] *Accord, Womens Services, P.C.* v. *Thone,* 483 F.Supp. 1022 (D.Neb.1979) (48 hours); *Women's Community Health Center, Inc.* v. *Cohen,* 477 F.Supp. 542 (D.Me.1979) (48 hours); *Leigh* v. *Olson,* No. A3-79-78 (D.N.D. preliminary injunction filed July 9, 1979) (48 hours); *But see Wolfe* v. *Schroering,* 541 F.2d 523 (6th Cir. 1976) (24 hours). (no argument that delay "significantly burdens the abortion process"); *Akron Center for Reproductive Health, Inc.* v. *City of Akron,* 479 F.Supp. 1172 (N.D.Ohio 1979) (24 hours).

tle proof as the woman's own declaration or written statement of her age would satisfy the statute. There is no constitutional infirmity.

[16] In the case of a minor, subsection 2 requires that not only she but also "her parent or legal guardian or person standing in loco parentis" be informed of specified information by the attending physician before she may obtain an abortion. The Court agrees with plaintiffs' contention that this regulation constitutes an undue burden on a minor seeking an abortion. The subsection make no distinction between a minor still living in her parents' home and an emancipated minor who might be living independently and at some distance from her parents or guardian. The requirement contains no exception, for instance, for parents who may be difficult to contact or who may live thousands of miles from the location of the attending physician. It does not provide that absent parents or parents impossible to contact may be informed constructively. As written in this subsection, the requirement that parents or guardian be informed prior to a minor obtaining an abortion could inject substantial delay into the process and, in some cases, could constitute an insurmountable obstacle. It is unconstitutional as an undue burden on a minor seeking an abortion.

[17] Plaintiffs' remaining objections to section 188.039 concern the specific information required to be presented by the attending physician to every woman seeking an abortion. This regulation to ensure "truly informed consent" must be considered in light of *Planned Parenthood* v. *Danforth,* in which the Supreme Court upheld a prior Missouri requirement that the woman give "informed" consent in writing. Answering a vagueness challenge to the term "informed," the Court stated, 428 U.S. at 67 n.8, 96 S.Ct. at 2840:

> [W]e are inclined to accept, as the meaning [of "informed" consent], the giving of information to the patient as to just what would be done and as to its conse-

> quences. To ascribe more meaning than this might well confine the attending physician in an undesired and uncomfortable straitjacket in the practice of his profession.

The Eighth Circuit interpreted that statement in *Freiman* v. *Ashcroft,* 584 F.2d 247, 251 (8th Cir. 1978), *summarily aff'd,* 440 U.S. 941, 99 S.Ct. 1416, 59 L.Ed.2d 630 (1979). "[T]he Supreme Court did not hold that a state may require physicians to provide to each patient any and all information required by the state, regardless of its legality, truth, constitutionality or medical advisability." The state has a legitimate interest in protecting women by ensuring that the decision to have an abortion is made with knowledge of the nature and consequences of the abortion procedure. *Planned Parenthood* v. *Danforth, supra.* However, specific regulations in this area may not, consistent with the reasoning in *Danforth,* have a "straitjacket" effect on the attending physician. There is a danger that specific information requirements may force the physician to do something *other* than what he considers to be best for his patient.[35]

The first two items require the physician to inform the woman "[t]hat according to the best medical judgment of her attending physician she is pregnant," and "[t]he number of weeks elapsed from the probable time of conception . . . ." Both plaintiffs' and defendants' experts testified that, apart from the statute, presenting such information to the patient seeking an abortion is good medical practice and would be done as a matter of course in almost all abortion cases. It is the exception which underlies plaintiffs' constitutional objection to these items.

[18] The procedure known as menstrual extraction is the removal of uterine contents prior to a positive pregnancy test. The purpose of the procedure is to correct a menstrual disorder and/or to abort a very early pregnancy.[36] At the stage at which the procedure is done it is not presently possible to determine whether the woman is in fact pregnant;[37] in practice the procedure is done with disregard to that question.[38] A menstrual extraction is intended to and in many cases does result in an abortion. Because the statute requires the physician to tell his patient that she *is* pregnant[39] and the length of her pregnancy prior to performing an abortion, a menstrual extraction performed prior to a positive pregnancy test and resulting in an abortion is unlawful. This could cause a woman seeking an early abortion to wait until such time as current technology enabled her physician to determine that she is in fact pregnant. A regulation which has the effect of outlawing a safe abortion technique utilized in the very early stages of pregnancy does not survive even rational basis inquiry.[40]

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[35] Testimony of Dr. Enrique Vera.

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[36] Dr. Robert Crist estimated that, within a reasonable medical certainty, 85% of those women with a menstrual period 10 days late are, in fact, pregnant.

[37] Testimony of Drs. Allen Palmer, Robert Crist, Robert Kretzschmar, and Richard Schmidt. There is nothing in this record to indicate the existence of a reliable pregnancy test at this early stage of pregnancy.

[38] Testimony of Dr. Allen Palmer.

[39] The statute does not require the physician to tell his patient *whether* she is pregnant; it requires the affirmative statement that she *is* pregnant.

[40] *Contra, Planned Parenthood* v. *Fitzpatrick,* 401 F.Supp. 554 (E.D.Pa.1975), *summarily aff'd sub nom. Franklin* v. *Fitzpatrick,* 428 U.S. 901, 96 S.Ct. 3202, 49 L.Ed.2d 1205 (1976) (this issue was not part of that appeal).

[19] The physician also is required to relate to every woman who seeks an abortion the "probable anatomical and physiological characteristics of the unborn child at the time the abortion is to be performed" and the "immediate and long-term physical dangers of abortion and psychological trauma resulting from abortion and any increased incidence of premature births, tubal pregnancies and still births following abortion." From the testimony and other evidence presented at trial, the Court concludes that these two items constitute an impermissible intrusion into the privacy of the doctor-patient relationship and interfere with the right of a woman to consult with her physician regarding abortion free from state interference.[41]

It is clear that many physicians believe that a mandatory presentation on fetal anatomy and physiology is not in the best health interests of many, if not all, of their patients seeking abortions. There was evidence that most women seeking an abortion do not desire such anatomical information[42] and that the giving of such information may have adverse effects in the form of emotional tension, increased anxiety and fright.[43] It is also clear that many physicians believe that there are no long-term physical or psychological effects of abortion or are unaware of such effects.[44] It is certainly not for this Court to say whether such long-term dangers actually exist. It is sufficient to note that the evidence demonstrates that many physicians believe that such information is highly debatable or is simply not factual, based on present medical knowledge.

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[41] Plaintiffs also make a strong argument that the requirement that the physician relate the "probable anatomical and physiological characteristics" of the fetus, enforced by criminal sanctions, is void for vagueness.

[42] Testimony of Dr. Robert Kretzschmar and Dr. Elizabeth Smith.

[43] Testimony of Drs. Allen Palmer, Robert Crist, Naim Kassar, and Enrique Vera. These experts also testified that such adverse emotional effects may require use of anesthetics in greater amounts, thereby increasing risk to the woman's health.

It is evident that such physicians, in the exercise of their best medical judgment, would choose not to provide their patients seeking abortions with a detailed anatomical description of the fetus. It is also evident that such physicians would choose not to provide information regarding long-term dangers they believe not to exist. These two requirements impose the "straitjacket" foreseen in *Planned Parenthood* v. *Danforth.* They mandate what must be presented by the physician *to each and every patient,* regardless of the doctor's view on the subject or his professional opinion of the medical advisability of presenting such information in any particular case. These requirements deprive the woman seeking an abortion of the right to consult with her physician and rely on his discretion and professional judgment. *Roe* v. *Wade, supra.*[45]

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[44] Testimony of Drs. Allen Palmer, Naim Kassar, Robert Crist, and Robert Kretzschmar. Dr. Richard Dickey testified to the contrary, that induced abortion may carry a risk to the woman's future fertility and may cause a greater likelihood of spontaneous abortion (miscarriage) in subsequent pregnancies.

[45] *See Freiman* v. *Ashcroft,* 584 F.2d 247 (8th Cir. 1978), *summarily aff'd,* 440 U.S. 941, 99 S.Ct. 1416, 59 L.Ed.2d 630 (1979); *Women's Services, P.C.* v. *Thone,* 483 F.Supp. 1022 (D.Neb.1979); *Akron Center for Reproductive Health, Inc.* v. *City of Akron,* 479 F.Supp. 1172 (N.D.Ohio 1979); *Leigh* v. *Olson,* No. A3-79-78 (D.N.D. preliminary injunction filed July 9, 1979).

[20-22] The final two items required to be presented to the woman seeking an abortion are "[t]he particular risks associated with the abortion technique to be used" and the "alternatives to abortion," including "a list of public and private agencies and services that will assist her during her pregnancy and after the birth of her child." Information regarding the risks associated with the technique to be employed and the alternatives available to the woman may be required by the state to ensure informed consent consistent with *Planned Parenthood* v. *Danforth*. *See Hodgson* v. *Lawson*, 542 F.2d 1350 (8th Cir. 1976); *Women's Services, P.C.* v. *Thone*, ____ F.Supp. ____ (D.Neb.1979). However, the requirement that the attending physician provide each of his patients with "a list of agencies" is void for vagueness. It is revealing to consider the range of testimony of both sides' experts describing the list which is required to be furnished, at the risk of criminal liability for noncompliance: "a list of *all* such agencies (there may be several hundred)"; "it is impossible to compile a complete list"; "it would include every agency in the metropolitan area"; "it would include only one public and one private agency"; "it would include only those agencies of which the physician was personally aware." A criminal statute which fails to give a person of ordinary intelligence fair notice of what is required or proscribed is unconstitutionally vague. *United States* v. *Harriss*, 347 U.S. 612, 617, 74 S.Ct. 808, 98 L.Ed. 989 (1954). The Court finds that the "list of agencies" requirement fails to provide physicians with the fair notice that is constitutionally required.

[23] The Court finds that the Missouri General Assembly would have enacted those parts of section 188.039 not declared unconstitutional independently from the stricken portions, and further finds that the valid provisions are not so connected and so dependent upon the stricken provisions as to preclude that finding. Accordingly, the provisions declared to be unconstitutional will be severed and stricken, allowing the remainder of the section to stand.[46] *See* § 1.140, RSMo; *United States* v. *Jackson,* 390 U.S. 570, 585, 88 S.Ct. 1209, 20 L.Ed.2d 138 (1968).

VII.

Pathology Report

[24] Section 188.047 requires that a sample of the tissue removed at the time of abortion be submitted to a pathologist, who must file copies of the tissue report with the facility at which the abortion is performed and with the state division of health. Plaintiffs contend that the additional cost of a tissue examination is unduly burdensome and that the requirement of an examination by a pathologist in every abortion case cannot be justified under traditional medical cost/benefit analysis; that such an examination in every case is simply unnecessary and serves no rational purpose.[47] The Court has not been shown that the increase in cost per abortion procedure resulting from the required tissue examination will constitute an undue burden on a woman seeking an abortion.[48] Defendants argue that the required tissue examination furthers the state's legitimate interest in the maintenance of good medical standards. In spite of plaintiffs' contentions that the tissue examination required by the statute is duplicative and not justifiable as a procedure to be done in every case, this Court cannot say that such a required examination is not rationally related to a legitimate state interest in the standard of medical care provided its citizens who undergo abortions.[49] The section is not unconstitutional. *See Wynn* v. *Scott,* 449 F.Supp. 1302, 1322 (N.D.Ill.1978), *aff'd,* 599 F.2d 193 (7th Cir. 1979).

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[46] Of course, the reference in § 188.039.1 to "the information contained in subsection 2 of this section" may refer constitutionally only to those portions of subsection 2 not delcared invalid.

[47] Plaintiff physicians testified that a gross or macroscopic examination of the tissue removed during abortion is done in any event by the performing physician, who then decides whether examination by a pathologist is indicated. Ms. Widdicombe testified that a tissue examination by a pathologist is ordered in only 12% of abortion cases at Reproductive Health Services' clinic.

[48] The expert's testimony regarding the cost per patient of a required tissue examination by a pathologist ranged from $10 to $40. Ms. Widdicombe's estimate of the cost of compliance for plaintiff Reproductive Health Services was $19.40 per abortion procedure.

VIII.

Reporting Requirements

[25] Section 188.052 imposes recordkeeping and reporting obligations regarding the abortion procedure itself and the treatment of any resulting complications.[50] The Court finds the requirements contained in this section to be consistent with the holding in *Planned Parenthood* v. *Danforth* and therefore constitutional. *See Hodgson* v. *Lawson,* 542 F.2d 1350 (8th Cir. 1976). As did the Supreme Court in *Danforth,* this Court relies on the assumption that such regulations will not be utilized and enforced in such a way as to constitute an undue burden through the sheer volume of recordkeeping.

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[49] Several of defendants' medical experts testified that pathology should be done in every case of abortion. Testimony of Drs. Bernard Nathanson, Pierre Keitges, Richard Schmidt, and Daniel Martin.

[50] Section 188.055 provides that all recordkeeping and reporting required under the Act shall be confidential and used only for statistical purposes.

IX.

Regulation of Abortion-Related Counseling

[26] Section 188.063 regulates counseling services relating to abortion. It sets minimum standards of education and training for counselors and regulates the content of counseling offered to pregnant women by requiring discussion of specified topics. The Court need not look beyond plaintiffs' equal protection argument.[51] By its own terms, the section applies only to an "abortion facility." The Act defines "abortion facility" as "a clinic, physician's office, or any other place or facility in which abortions are performed *other than a hospital.*" § 188.015(2), RSMo (the Court's emphasis). Thus, the section regulates counseling services relating to abortion offered in clinics, such as those operated by the corporate plaintiffs, but leaves the same services unregulated if offered in a hospital. Defendants offer no justification, either related to the purpose of the regulation or otherwise, for such difference in treatment. With respect to abortion-related counseling services, the Court finds no rational reason for the distinction between hospitals and abortion facilities other than hospitals. The section is unconstitutional as violative of the equal protection clause of the fourteenth amendment of the Constitution.

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[51] Plaintiffs make a compelling argument that the section is also void for vagueness because it involves the imposition of criminal liability for behavior to be measured by vague statutory standards, *e. g.*, "appropriate field," "factual information," "not to be misleading," "explicit discussion," and "thorough discussion."

X.

Conclusion

For the reasons above-stated, the following portions of the 1979 Missouri act relating to the regulation of abortions are hereby declared to be unconstitutional:

1. § 188.025;
2. § 188.028;
3. § 188.030;
4. The following portions of § 188.039:

   A. From § 188.039.1, the phrase "not less than forty-eight hours prior to her consent to the abortion,";

   B. From § 188.039.2, the phrase "and, if she is a minor, her parent or legal guardian or person standing in loco parentis";

   C. § 188.039.2(1)-(4);

   D. From § 188.039.2(6), the phrase "including a list of public and private agencies and services that will assist her during her pregnancy and after the birth of her child."
5. § 188.063.

[27] At the conclusion of trial, defendants stated on the record that they will abide by this Court's declaration regarding the validity of any part of the Act. The Court assumes that all prosecutorial authorities of the State of Missouri will likewise abide by this Court's judgment. Accordingly, no injunctive order will issue at this time.

IT IS SO ORDERED.

APPENDIX

AN ACT to repeal sections 188.015, 188.020, 188.025, 188.030, 188.035, 188.050, 188.055, 188.060, and 188.075, RSMo 1978, relating to regulation of abortions, and to enact in lieu thereof fifteen new sections relating to the same subject, with penalty provisions and an emergency clause.

Be it enacted by the General Assembly of the State of Missouri, as follows:

Section 1. Sections 188.015, 188.020, 188.025, 188.030, 188.035, 188.050, 188.055, 188.060 and 188.075, RSMo 1978 are repealed and fifteen new sections enacted in lieu thereof, to be known as sections 188.015, 188.020, 188.025, 188.027, 188.028, 188.030, 188.035, 188.037, 188.039, 188.047, 188.052, 188.055, 188.060, 188.063 and 188.75, to read as follows:

188.015. Unless the language or context clearly indicates a different meaning is intended, the following words or phrases for the purposes of sections 188.010 to 188.085 shall be given the meaning ascribed to them:

(1) "Abortion", the intentional destruction of the life of an embryo or fetus in his or her mother's womb or the intentional termination of the pregnancy of a mother with an intention other than to increase the probability of a live birth or to remove a dead or dying unborn child;

(2) "Abortion facility", a clinic, physician's office, or any other place of facility in which abortions are performed other than a hospital;

(3) "Conception", the fertilization of the ovum of a female by the sperm of a male;

(4) "Physician", any person licensed to practice medicine in this state by the state board of registration of the healing arts;

(5) "Unborn child", the offspring of human beings from the moment of conception until birth and at every stage of its biological development, including the human conceptus, zygote, morula, blastocyst, embryo, and fetus;

(6) "Viability", that stage of fetal development when the life of the unborn child may be continued indefinitely outside the womb by natural or artificial life-supportive systems.

188.020. No person shall perform or induce an abortion except a physician.

188.025. Every abortion performed subsequent to the first twelve weeks of pregnancy shall be performed in a hospital.

188.027. No abortion shall be performed except with the prior, informed and written consent freely given of the pregnant woman.

188.028. 1. No person shall knowingly perform an abortion upon a pregnant woman under the age of eighteen years unless:

(1) The attending physician has secured the informed written consent of the minor and one parent or guardian; or

(2) The minor is emancipated and the attending physician has received the informed written consent of the minor; or

(3) The minor has been granted the right to self-consent to the abortion by court order pursuant to subsection 2 of this section, and the attending physician has received the informed written consent of the minor; or

(4) The minor has been granted consent to the abortion by court order, and the court has given its informed written consent in accordance with subsection 2 of this section, and the minor is having the abortion willingly, in compliance with subsection 3 of this section.

2. The right of a minor to self-consent to an abortion under subdivision (3) of subsection 1 of this section or court consent

under subdivision (4) of subsection 1 of this section may be granted by a court pursuant to the following procedures:

(1) The minor or next friend shall make an application to the juvenile court which shall assist the minor or next friend in preparing the petition and notices required pursuant to this section. The minor or the next friend of the minor shall thereafter file a petition setting forth the initials of the minor; the age of the minor; the names and addresses of each parent, guardian, or, if the minor's parents are deceased and no guardian has been appointed, any other person standing in loco parentis of the minor; that the minor has been fully informed of the risks and consequences of the abortion; that the minor is of sound mind and has sufficient intellectual capacity to consent to the abortion; that, if the court does not grant the minor majority rights for the purpose of consent to the abortion, the court should find that the abortion is in the best interest of the minor and give judicial consent to the abortion; that the court should appoint a guardian ad litem of the child; and if the minor does not have private counsel, that the court should appoint counsel. The petition shall be signed by the minor or the next friend;

(2) Copies of the petition and a notice of the date, time, and place of the hearing shall be personally served upon each parent, guardian or, if the minor's parents are deceased and no guardian has been appointed, any other person standing in loco parentis of the minor listed in the petition by the sheriff or his deputy. If a parent or guardian or, if the minor's parents are deceased and no guardian has been appointed, any other person standing in loco parentis cannot be personally served within two days after reasonable effort, the sheriff or his deputy shall give constructive notice to them by certified mail to their last known address and the hearing shall not be held for at least forty-eight hours from the time of the mailing. In any case where there exists the potential or appearance of conflict of interests between the parents or guardian or next friend of the child and the child, the court shall appoint a guardian ad litem to defend the

minor's interests. The court shall set forth, for the record, the grounds for such appointment;

(3) A hearing on the merits of the petition, to be held on the record, shall be held as soon as possible within five days of the filing of the petition. If any party is unable to afford counsel, the court shall appoint counsel at least twenty-four hours before the time of the hearing. At the hearing, the court shall hear evidence relating to the emotional development, maturity, intellect and understanding of the minor; the nature, possible consequences, and alternatives to the abortion; and any other evidence that the court may find useful in determining whether the minor should be granted majority rights for the purpose of consenting to the abortion or whether the abortion is in the best intesters of the minor;

(4) In the decree, the court shall for good cause:

(a) Grant the petition for majority rights for the purpose of consenting to the abortion; or

(b) Find the abortion to be in the best interests of the minor and give judicial consent to the abortion, setting forth the grounds for so finding; or

(c) Deny the petition, setting forth the grounds on which the petition is denied;

(5) If the petition is allowed, the informed consent of the minor, pursuant to the court grant of majority rights, or the judicial consent, shall bar an action by the parents or guardian of the minor on the grounds of battery of the minor by those performing the abortion. The immunity granted shall only extend to the performance of the abortion in accordance herewith and any necessary accompanying services which are performed in a competent manner. The costs of the action shall be borne by the parties.

(6) An appeal from an order issued under the provisions of this section may be taken to the court of appeals of this state by the minor or by a parent or guardian of the minor. The notice of intent to appeal shall be given within twenty-four hours from the date of issuance of the order. The record on appeal shall be completed and the appeal shall be perfected within five days from the filing of notice to appeal. Because time may be of the essence regarding the performance of the abortion, the supreme court of this state shall, by court rule, provide for expedited appellate review of cases appealed under this section.

3. If a minor desires an abortion, then she shall be orally informed of and, if possible, sign the written consent required by section 188.039 in the same manner as an adult person. No abortion shall be performed on any minor against her will, except that an abortion may be performed against the will of the minor pursuant to the court order described in subdivision (4) of subsection 1 of this section that the abortion is necessary to preserve the life of the minor.

188.030. 1. No abortion of a viable unborn child shall be performed unless necessary to preserve the life or health of the woman. Before a physician may perform an abortion upon a pregnant woman after such time as her unborn child has become viable, such physician shall first certify in writing that the abortion is necessary to preserve the life or health of the woman and shall further certify in writing the medical indications for such abortion and the probable health consequences.

2. Any physician who performs an abortion upon a woman carrying a viable unborn child shall utilize the available method or technique of abortion most likely to preserve the life and health of the unborn child. In cases where the method or technique of abortion which would most likely preserve the life and health of the unborn child would present a greater risk to the life and health of the woman than another available method or technique, the physician may utilize such other method or

technique. In all cases where the physician performs an abortion upon a viable unborn child, the physician shall certify in writing the available method or techniques considered and the reasons for choosing the method or technique employed.

3. An abortion of a viable unborn child shall be performed or induced only when there is in attendance a physician other than the physician performing or inducing the abortion who shall take control of and provide immediate medical care for a child born as a result of the abortion. During the performance of the abortion, the physician performing it, and subsequent to the abortion, the physician required by this section to be in attendance, shall take all reasonable steps in keeping with good medical practice, consistent with the procedure used, to preserve the life and health of the viable unborn child; provided that it does not pose an increased risk to the life or health of the woman

188.035. Whoever, with intent to do so, shall take the life of a child aborted alive, shall be guilty of murder of the second degree.

188.037. No person shall use any fetus or child aborted alive for any type of scientific, research, laboratory or other kind of experimentation either prior to or subsequent to any abortion procedure except as necessary to protect or preserve the life and health of such fetus or child aborted alive.

188.039. 1. No physician shall perform an abortion unless, prior to such abortion, the physician certifies in writing that the woman gave her informed consent, freely and without coercion, after the attending physician had informed her of the information contained in subsection 2 of this section not less than forty-eight hours prior to her consent to the abortion, and shall further certify in writing the pregnant woman's age, based upon proof of age offered by her.

2. In order to insure that the consent for an abortion is truly informed consent, no abortion shall be performed or induced

upon a pregnant woman unless she has signed a consent form that shall be supplied by the state division of health, acknowledging that she and, if she is a minor, her parent or legal guardian or person standing in loco parentis have been informed by the attending physician of the following facts:

(1) That according to the best medical judgment of her attending physician she is pregnant;

(2) The number of weeks elapsed form the probable time of conception of her unborn child, based upon the information provided by her as to the time of her last menstrual period and after a history and physical examination and appropriate laboratory tests;

(3) The probable anatomical and physiological characteristics of the unborn child at the time the abortion is to be performed;

(4) The immediate and long-term physical dangers of abortion and psychological trauma resulting from abortion and any increased incidence of premature births, tubal pregnancies and still births following abortion;

(5) The particular risks associated with the abortion technique to be used;

(6) Alternatives to abortion shall be given by the attending physician, including a list of public and private agencies and services that will assist her during her pregnancy and after the birth of her child.

3. The physician may inform the woman of any other material facts or opinions, or provide any explanation of the above information which, in the exercise of his best medical judgment, is reasonably necessary to allow the woman to give her informed consent to the proposed abortion, with full knowledge of its nature and consequences.

188.047. A representative sample of tissue removed at the time of abortion shall be submitted to board eligible or certified pathologist, who shall file a copy of the tissue report with the state division of health, and who shall provide a copy of the report to the abortion facility or hospital in which the abortion was performed or induced and the pathologist's report shall be made a part of the patient's permanent record.

188.052. 1. An individual abortion report for each abortion performed or induced upon a woman shall be completed by her attending physician.

2. An individual complication report for any post-abortion care performed upon a woman shall be completed by the physician providing such post-abortion care. This report shall include:

(1) The date of the abortion;

(2) The name and address of the abortion facility or hospital where the abortion was performed;

(3) The nature of the abortion complication diagnosed or treated.

3. All abortion reports shall be signed by the attending physician, and submitted to the state division of health within forty-five days from the date of the abortion. All complication reports shall be signed by the physician providing the post-abortion care and submitted to the division of health within forty-five days from the date of the post-abortion care.

4. A copy of the abortion report shall be made a part of the medical record of the patient of the facility or hospital in which the abortion was performed.

5. The state division of health shall be responsible for collecting all abortion reports and complication reports and collating and evaluating all data gathered therefrom and shall annually publish a statistical report based on such data from abortions performed in the previous calendar year.

188.055. 1. Every abortion facility, hospital, and physician shall be supplied with forms by the division of health for use in regards to the consents and reports required by sections 188.010 to 188.085. A purpose and function of such consents and reports shall be the preservation of maternal health and life by adding to the sum of medical knowledge through the compilation of relevant maternal health and life data and to monitor all abortions performed to assure that they are done only under and in accordance with the provisions of the law.

2. All information obtained by physician, hospital, or abortion facility from a patient for the purpose of preparing reports to the division of health under sections 188.010 to 188.085 or reports received by the division of health shall be confidential and shall be used only for statistical purposes. Such records, however, may be inspected and health data acquired by local, state, or national public health officers.

188.060. All medical records, reports, and other documents required to be kept under sections 188.010 to 188.085 shall be maintained in the permanent files of the abortion facility or hospital in which the abortion was performed for a period of seven years.

188.063. No abortion facility shall advertise or hold itself out as also providing counseling to pregnant women unless:

(1) The counseling is done by a licensed physician, registered nurse or other person holding at least a bachelor's degree from an accredited college or university in psychology or appropriate field or having completed special training in counseling;

(2) The counseling includes factual information given in such a manner as to not be misleading, including explicit discussion of the development of the unborn child; and

(3) The counseling includes a thorough discussion of alternatives to abortion and availability of agencies and services to assist her if she chooses to carry her child to term.

2. The prescribed course of study which shall constitute special training in counseling shall be promulgated by the division of health. Any rule or portion of a rule promulgated pursuant to this chapter may be suspended by the joint committee on administrative rules if after hearing thereon the committee finds that such rule or portion of the rule is beyond or contrary to the statutory authority of the agency which promulgated the rule, or is inconsistent with the legislative intent of the authorizing statute. The general assembly may reinstate such rule by concurrent resolution signed by the governor.

188.075. Any person who contrary to the provisions of sections 188.010 to 188.085 knowingly performs or aids in the performance of any abortion or knowingly fails to perform any action required by sections 188.010 to 188.085 shall be guilty of a class A misdemeanor and, upon conviction, shall be punished as provided by law.

Section A. Because of the necessity for immediate state action to regulate abortions to protect the lives and health of citizens of this state, this act is deemed necessary for the immediate preservation of the public health, welfare, peace and safety, and is hereby declared to be an emergency act within the meaning of the constitution, and this act shall be in full force and effect upon its passage and approval.

APPENDIX B

PLANNED PARENTHOOD ASSOCIATION OF KANSAS CITY, MISSOURI, INC., Naim S. Kassar, M.D., Reproductive Health Services, Allen S. Palmer, D.O., Appellees,

v.

John ASHCROFT, Attorney General of State of Missouri, Ralph L. Martin, Prosecuting Attorney of Jackson County, Missouri, Appellants.

PLANNED PARENTHOOD ASSOCIATION OF KANSAS CITY, MISSOURI, INC., Naim S. Kassar, M.D., Reproductive Health Services, Allen S. Palmer, D.O., Appellants,

v.

John ASHCROFT, Attorney General of State of Missouri, Ralph L. Martin, Prosecuting Attorney of Jackson County, Missouri, Appellees.

Nos. 80-1130, 80-1530.

United States Court of Appeals,

Eighth Circuit.

Submitted Nov. 17, 1980.

Decided July 8, 1981.

Before LAY, Chief Judge, HENLEY, Circuit Judge, and HARRIS,* Senior Judge.

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* Oren Harris, Senior District Judge, Eastern and Western Districts of Arkansas, sitting by designation.

LAY, Chief Judge.

This is an appeal and cross-appeal relating to the constitutionality of the Missouri statutes regulating abortion.[1] The trial court denied injunctive relief, but issued a declaratory judgment holding all or part of five sections of the Missouri statutes unconstitutional

Allen S. Palmer, D.O., and Naim S. Kansar, M.D., licensed physicians, and Planned Parenthood and Reproductive Health Services, corporations that operate abortion clinics in Kansas City and St. Louis,[2] brought suit against John Ashcroft, Attorney General of Missouri, and Ralph Martin, prosecuting attorney of Jackson County, Missouri (in his capacity as Jackson County prosecutor and as representative of the class of Missouri prosecutors).[3]

On appeal the Missouri defendants challenge the district court holding on the unconstitutionality of a provision requiring second trimester abortions to be performed in a hospital, parental or judicial consent requirements for minors, restrictions on abortion of viable fetuses, and "informed consent" requirements. They also challenge the award of attorneys' fees. Planned Parenthood cross-appeals from the district court's refusal to declare unconstitutional provisions requiring: (1) that the "informed consent" information must be given by the attending physician; (2) submission of tissue samples from all abortions to a pathologist; and (3) completion of individual reports on women seeking post-abortion care.[4]

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[1] The district court's opinion is published at 483 F.Supp. 679.

[2] In order to simplify discussion plaintiffs are hereinafter referred to collectively as "Planned Parenthood".

[3] In order to simplify discussion defendants are hereinafter referred to as "Missouri".

We affirm in part, reverse in part and remand for further proceedings.

In summary, we first find that the district court erred in concluding on the present record that the State's requirement that all second trimester abortions be performed in a hospital is unconstitutional. We find that the fact that hospitals allegedly require parental consent for the admission of minors is not an unconstitutional burden imposed by the State. We nonetheless remand this issue to the district court for further findings as to whether the hospitalization requirement is a substantial burden on women patients seeking abortions in the second trimester (at least up to 18 weeks) and if so whether the State has shown a compelling state interest which justifies the requirement.

We reverse the district court's finding that section 188.030 of the Missouri statutes imposed strict criminal liability on doctors who may abort viable fetuses. We find the Missouri law requires scienter (knowledge) by the physician such that it comports with constitutional requirements. We also reverse the district court's holding that subsection 188.030.2 is unconstitutionally vague.

We likewise find the district court erred in holding the provisions relating to parental or judicial consent for a minor's abortion unconstitutional. We think proper interpretation of the judicial consent provision requires a court to grant judicial consent to a mature minor or a minor for whom an abortion is in her best interests. We find, however, that the provision requiring notice to the parents of all minors is unconstitutional because it requires notice to the parents of minors who are mature or minors for whom it is not in their best interest to give notice. We find the remaining portion of section 188.028 constitutional.

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[4] On June 30, 1979, the district court issued a temporary restraining order to prevent enforcement of the challenged statutes. This order was modified on September 27, 1979. At the conclusion of the trial, the defendants gave assurances that portions of the Act declared unconstitutional would not be enforced. 483 F.Supp. at 701.

The district court also dealt with other provisions of the Missouri statutes, but its conclusions on those questions are not challenged on appeal.

We affirm the district court's finding that the requirement of a second doctor during a second trimester abortion is unconstitutional. We likewise affirm its finding that the 48 hour waiting period is unconstitutional. We also agree with the district court that the informed consent provision requiring notice to parents and the provisions for informed consent under subsections 188.039.2(1), (2), (3), and (4) are unconstitutional. We uphold the district court's findings that the State may require the attending physician to inform the woman as to the particular medical risks associated with the abortion technique to be used and the available alternatives.

Finally, we agree with the district court there is nothing impermissible in the abortion complication reports required by the State. We find section 188.047, requiring pathology reports following all abortions to be an impermissible requirement. We vacate and remand to the district court for reconsideration the constitutionality of the abortion complication reports required under section 188.052.2.

We affirm the district court's award of attorney fees.

I. *Second Trimester Hospitalization Requirement.*

Section 188.025[5] requires that second and third trimester abortions be performed in a hospital. The district court held that this requirement did not reasonably relate to protection of maternal health, because the dilatation and evacuation method (D&E) could be performed safely outside of a hospital up until the 18th week. The court observed that the effect of the hospitalization requirement was to make a second trimester D&E unavailable in Missouri because only one hospital in the state allows D&E in the second trimester. Alternatively, the court held that this requirement granted parents the power to veto a minor women's decision to have an abortion contrary to *Planned Parenthood* v. *Danforth,* 428 U.S. 52, 96 S.Ct. 2831, 49 L.Ed.2d 788 (1976), because no hospital in Missouri would admit a woman under 18 without parental consent. 483 F.Supp. at 685—87.[6]

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[5] Section 188.025 states:

Every abortion performed subsequent to the first twelve weeks of pregnancy shall be performed in a hospital.

Mo.Ann.Stat. § 188.025 (Vernon).

[6]. Several district courts have recently considered similar challenges to second trimester hospitalization requirements. *See Wolfe* v. *Stumbo,* No. C 80—0285 L(A) (W.D.Ky. Dec. 3, 1980) (unconstitutional); *Gary-Northwest Indiana Women's Services* v. *Bowen,* 496 F.Supp. 894 (N.E.Ind.1980), *aff'd sub nom. Gary-Northwest Indiana Women's Services* v. *Orr,* ___ U.S. ___, 101 S.Ct. 2012, 68 L.Ed.2d 321 (1981) (constitutional); *Margaret S.* v. *Edwards,* 488 F.Supp. 181 (E.D.La.1980) (unconstitutional). *See also Wynn* v. *Scott,* 449 F.Supp. 1302, 1318 (N.D.Ill.1978), *aff'd sub nom, Wynn* v. *Carey,* 599 F.2d 193 (7th Cir. 1979) (hospitalization requirement constitutional; no discussion of D&E method); *Hodgson* v. *Lawson,* 542 F.2d 1350, 1354 (8th Cir. 1976) ("The requirement . . . that an abortion be performed in a hospital, which is not challenged here, is an example of permissible state regulation subsequent to the first trimester.").

A. *Parental Consent for Hospitalization.*

We first address the finding made by the district court that since all hospitals in Missouri require parental consent for abortion to minors the effect of a statute requiring hospitalization is to grant parents the absolute veto forbidden by *Planned Parenthood* v. *Danforth,* 428 U.S. 52, 96 S.Ct. 2831, 49 L.Ed.2d 788 (1976). We must respectfully disagree.

The district court's holding goes a step beyond *Danforth.* In *Danforth,* the *state* required parental consent as a prerequisite for a minor to have an abortion, thus directly interfering with the woman's decision. The present Missouri hospitalization requirement says nothing about parental consent and the State itself has not given parents a veto power.[7] Instead, the State has imposed second trimester regulations that it claims are within the State's regulatory power in the second trimester because they are reasonably related to the woman's health. *Roe* v. *Wade,* 410 U.S. 113, 164, 93 S.Ct. 705, 732, 35 L.Ed.2d 147 (1973). The district court's holding would mean that the State could not impose such regulations if they created a situation in which the acts of private entities could interfere with the woman's decision. The problem with this approach to the *Roe* rule is that it would force reevaluation of every health-based second trimester regulation to determine its practical effect, without concern for its health-based justification. For example, Missouri requires that all abortions be performed by a physician. Private physicians may choose not to perform abortions.

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[7] Missouri also argues that the testimony at trial failed to show that *no* hospitals in the state will admit minors for abortion without parental consent. There was no testimony from any person claiming knowledge of the policies of hospitals throughout the state that no hospital would admit a minor without parental consent. Missouri likewise urges that the record demonstrates that many abortions are performed by physicians on an outpatient basis without direct admission to the hospital.

if statistics showed that no physicians in the state or in some geographic area of the state were willing to perform second trimester abortions on minors without parental consent, the district court's logic would declare the physician requirement unconstitutional.

[1,2] The point is that when dealing with second trimester regulations, *Roe* declares that the *sole* question is whether the regulation reasonably relates to the woman's health.[8] If the regulation bears a reasonable relation to health, the regulation may and probably will restrict the woman's options. It may also put some private parties in a position where they may impose regulations or costs that restrict the options of some women. But if the statute is reasonably related to health, the fact that private entities (i. e., the hospitals) impose additional requirements without the State's sanction or insistence cannot affect the statute's constitutionality.[9] We reject the district court's alternative ground for finding section 188.025 unconstitutional.

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[8] As *Danforth* indicates, the practical availability of safe alternatives is a consideration in determining the rationality of a prohibition on particular methods. Where the state has forbidden relatively safe method on the rationale that equally safe or safer methods are available, the court must consider the actual availability of these alternatives. Practical obstacles, such as a consent requirement, may enter into this evaluation. However, the inquiry remains whether the regulation is one reasonably related to the women's health.

[9] "Our cases state 'that a State is responsible for the . . .act of a private party when the State, by its law, has compelled the act." *Adickes* [v. *S.H. Kress & Co.*,] 398 U.S. [144,] 170, [90 S.Ct. 1598, 1615, 26 L.Ed.2d 142] [(1970)]. This Court, however, has never held that a State's mere acquiescence in a private action converts that action into that of the State." *Flagg Bros., Inc.* v. *Brooks*, 436 U.S. 149, 164, 98 S.Ct. 1729, 1737, 56 L.Ed.2d 185 (1978).

If it is true that no hospitals in Missouri will admit minor women without parental consent, and we agree the evidence is not convincing in this respect, the plaintiffs may wish to direct their attention to the actions of the hospitals. We express no view on the merits of this argu-

B. Effect on Availability of Second Trimester Abortions.

The district court held that the hospitalization requirement unconstitutionally restricted the availability of second trimester abortions. We conclude that is is not clear that the district court applied the proper legal standard or that the factual findings underlying this holding are adequate. A remand for further proceedings is necessary to provide us with an adequate basis for review of the constitutionality of the hospitalization requirement.

[3,4] In 1973 *Roe* v. *Wade* addressed whether a second trimester hospitalization requirement is a permissible regulation:

> Examples of permissible state regulation in this area are requirements as to the qualifications of the person who is to perform the abortion; as to the licensure of that person; as to the facility in which the procedure is to be performed, that is, *whether it must be a hospital or may be a clinic or some other place of less-than-hospital status;* as to the licensing of the facility; and the like.

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ment, but insofar as particular hospitals have characteristics which render their actions "state action", parental consent requirements arguably violate *Danforth's* prohibition against an absolute parental veto. *Cf. Nyberg* v. *City of Virgina,* 495 F.2d 1342 (8th Cir.), *appeal dismissed,* 419 U.S. 891, 95 S.Ct. 169, 42 L.Ed.2d 136 (1974) (unconstitutional for public hospital to refuse facilities to perform elective abortions); *Hodgson* v. *Lawson,* 542 F.2d 1350 (8th Cir. 1976); *Wolfe* v. *Schroering,* 541 F.2d 523, 527 (6th Cir. 1976); *Doe* v. *Charleston Area Medical Center, Inc.,* 529 F.2d 638 (4th Cir. 1975); *Doe* v. *Hale Hospital,* 500 F.2d 144 (1st Cir. 1974); *cert. denied,* 420 U.S. 907, 95 S.Ct. 825, 42 L.Ed.2d 837 (1975). *Poelker* v. *Doe,* 432 U.S. 519, 97 S.Ct. 2391, 53 L.Ed.2d 528 (1977), held that a city operating a municipal hospital need not provide publicly financed hospital services for abortions for indigent women. It does not hold that a state hospital may refuse to allow physicians to perform paid abortions in the hospital, which was the issue in *Nyberg.*

410 U.S. at 163, 93 S.Ct. at 732 (emphasis added).

See also Gary-Northwest Indiana Women's Services v. *Bowen,* 496 F.Supp. 894 (N.D. Ind.1980), *aff'd sub nom. Gary-Northwest Indiana Women's Services* v. *Orr,* ____ U.S. ____, 101 S.Ct. 2012, 68 L.Ed.2d 321 (1981).

Missouri argues *Roe* is dispositive here. On the basis of the record and contentions of the parties we deem the issue not so easily resolved. In 1973, when *Roe* was written D&E was not a well-known and common means of performing second trimester abortions. The record demonstrates that today D&E is the most often utilized and safest procedure for second trimester abortion up to 15 weeks. 483 F.Sup. at 685 n.9, & 686 n.13. Yet the district court found that D&E is not generally available to women seeking abortions in Missouri hospitals.[10] It was on this basis the district court found the hospitalization requirement invalid. We perceive the settled standard in reviewing state regulation of abortion rights of the mother to be (1) whether the state requirement imposes a substantial interference and burden on the woman's decision to have an abortion and if so (2) whether the state has shown a compelling basis for the law, that is, that the burden is not undue or unjustifiable. *See Charles* v. *Carey,* 627 F.2d 772 (7th Cir. 1980). In applying the strict scrutiny test, it, of course, must be acknowledged that the state has a compelling interest in the health of the mother and may regulate abortion "in ways that are reasonably related to maternal health." 410 U.S. at 164, 93 S.Ct. at 732.

We view the findings of the district court on this basis.

The conclusion of the district court that second trimester D&E is available in only one hospital in Missouri rests on a thin reed. The conclusion is based solely on the personal knowledge of two physicians, neither one of whom testified that he was familiar with the policies of the hospitals throughout the state[11]. Second, although the record suggests that hospitalized D&Es, when available, are more expensive than nonhospitalized D&Es and that the overall effect of the hospitalization requirement has been to substantially reduce the number of second trimester abortions in Missouri, the district court made no findings. We think it essential the district court evaluate this overall testimony and make findings in this regard. We think it likewise essential that the record should be factually supplemented as to the availability or nonavailability of D&E procedures in hospitals throughout the state.

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[10] The record does not make clear why D&E is not readily available for hospitalized second trimester abortions.

[5] From these factual conclusions the district court must then determine whether or not the hospitalization requirement imposes a substantial interference and burden on the woman's decision to have an abortion. Perhaps one can assume that it is implicit in the district court's opinion that mandated second trimester hospitalization limits the accessibility of abortion in Missouri, but based on the court's analysis it is not clear whether the correct legal standard was applied. We think it fundamental that the district court explicitly address the threshold question: Whether the hospital regulation directly interferes with the woman's decision to terminate her pregnancy. Assuming the district court, based on the evidence, answers this question in the affirmative, then the regulation comes under the strict scrutiny standard and the State has the burden to justify the regulation by demonstrating a compelling state interest.

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[11] Dr. Palmer was asked "Are you familiar with any hospital within the St. Louis metropolitan area that performs D&E second trimester procedures?" A. "No." (T. 135). Dr. Kassar was asked "Do you know of any other hospital in the State of Missouri which allows the use of dilation and evacuation in the second trimester?" A. "Not to my knowledge." (T. 257).

In this regard, the district court properly considered the Supreme Court's previous evaluation of second trimester abortion regulations in *Planned Parenthood* v. *Danforth,* 428 U.S. 52, 75-79, 96 S.Ct. 2831, 2843—2846, 49 L.Ed.2d 788 (1976). The Court found that the saline amniocentesis method, prohibited by a Missouri statute, was the most prevalent second trimester method and that supposedly safer alternatives (i. e., prostaglandins) were not readily available. Under these circumstances, the Court concluded that the prohibition against saline was not reasonably related to the woman's health since it prevented use of a method that was safer for the woman than the available alternatives.

If the district court finds the hospital requirement constitutes a direct interference with the woman's decision to have an abortion the court must then determine whether Missouri's requirement reasonably relates to the protection of the woman's health. The State, in meeting this burden, must show that nonhospitalized D&E can reasonably be considered more dangerous than hospital procedures, including hospitalized D&E. It must also show that the methods that it argues are as safe or safer than nonhospitalized D&E are actually available to Missouri women. *Cf. Planned Parenthood* v. *Danforth,* 428 U.S. at 77 & n.12, 96 S.Ct. at 2845 & n.12 (burden on state to show availability). Missouri cannot "force a woman and her physician to terminate her pregnancy by methods more dangerous to her health than the method outlawed." *Id.* at 79, 96, S.Ct. at 2845.

From this discussion it is clear that the central issue is the relative safety of nonhospitalized D&E and hospitalized methods. The record contains conflicting testimony about safety. Experts called by Planned Parenthood claim nonhospitalized D&E is *safer* than all hospitalized procedures, because hospitals create greater risks of infection, cause greater anxiety, and use general anesthesia. They also point to recent standards issued by the American Public Health Association and the

American College of Obstetricians and Gynecologists, retracting their previous recommendation for hopsitalization for second trimester abortions. On the other hand, the State's witnesses claim that hospitalization is essential because of the increased risks in the second trimester. The district court made no finding as to the relative safety of nonhospitalized and hospitalized methods.[12] On remand, if the district court determines that the hospital requirement imposes a substantial interference and burden on the woman's decision to have an abortion then the court should make explicit findings as to the safety of nonhospitalized D&E compared to hospitalized methods.

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[12] The district court stated:

On the record before it, this Court is convinced that aside from the question whether it is performed in a hospital or in an out-patient clinic,[12] dilatation and evacuation is the safest of the presently available post-twelve week abortion techniques.[13]

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[12] Dr. Bernard Nathanson, one of defendants' experts, testified that the morality (sic) and morbidity rates for D&E procedures performed outside a hospital were probably no different than those performed in a hospital.

[13] Mortality rates (per 100,000 cases) for post-12 week abortion techniques for the years 1972—1977 are as follows:

D & E	8.3
Prostaglandins and other agents	10.8
Saline instillation	15.5
Hysterotomy and hysterectomy	45.3

Center for Disease Control, U. S. Dep't. of H. E. W., *Abortion Surveillance 1977,* Table 23.

483 F.Supp. at 686.

The quoted sentence from the test of the district court's opinion is ambiguous. It can be read as saying that it is not necessary to decide whether D&E is safer in a hospital or outside a hospital and that it suffices to say that if you average the mortality from D&E in hospitals and outside hospitals, D&E is safer than other methods. It can also be read as saying that D&E is equally safe in a hospital or outside a

In sum, we find that the district court failed to properly analyze the hospitalization requirement. On remand, it should first determine if the regulation creates substantial interference with and imposes a direct burden on the woman's decision to have an abortion. If it does, the district court should evaluate whether the hospitalization requirement is justified by a compelling state interest; i. e., whether it is reasonably related to the woman's health. Missouri bears the burden of justifying the restriction. We therefore vacate the district court's finding that Missouri's hospitalization requirement is unconstitutional. We remand this question back to the district court by certification and request the district court to take additional evidence, if deemed necessary by the parties or by the court, and to make additional findings in accord with this opinion. We respectfully request the district court to certify the record and its findings back to this court within 90 days.

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hospital, and that the D&E safety rate exceeds all other methods. The first reading would be an inadequate finding, since to invalidate a hospitalization requirement we must know the safety effects of hospitalization. General conclusions which average the two safety rates do not answer that question.

The footnotes do not resolve the ambiguity. The court refers to Dr. Nathanson's testimony that D&E is probably equally safe in a hospital or outside a hospital, but there is no finding to that effect. In footnote 13, the court refers to a study concluding that the mortality rate for D&E is lower than the mortality rate for other methods. These statistics do not distinguish between hospitalized D&E and nonhospitalized D&E, so there is no way to determine from them whether a nonhospitalized D&E is significantly safer than the other available methods.

Planned Parenthood argues that the record supports a finding that nonhospitalized D&E is as safe or safer than hospitalized D&E. It is true that several physicians testified to that effect. However there were also expert witnesses who disagreed. Since there are apparently no statistics that distinguish between hospitalized and nonhospitalized procedures, the conclusion depends upon an evaluation of the relative weight to be given the testimony of the experts. We decline to make a finding from the cold record where it depends on the credibility of the experts, a question uniquely within the province of the district court.

II. *Parental or Court Consent For Minors.*

Section 188.028 prohibits abortions for women under 18 unless parental or court consent is obtained. The district court declared this section unconstitutional. In *Planned Parenthood* v. *Danforth*, 428 U.S. 52, 96 S.Ct. 2831, 49 L.Ed.2d 788 (1976), the Court declared that a state requirement that all minors obtain parental consent prior to obtaining an abortion was unconstitutional. In *Bellotti* v. *Baird* (Bellotti II), 433 U.S. 622, 99 S.Ct. 3035, 61 L.Ed.2d 797 (1979), four justices concluded that the Massachusetts statute requiring judicial approval in lieu of parental consent was unconstitutional in part because it allowed a court to deny permission based on its perception of the woman's "best interests", even when a minor was mature enough to make her own decision. These four justices (Powell, Burger, Rehnquist and Stewart) described a procedure that would satisfy constitutional requirements:

> A pregnant minor is entitled in such a proceeding to show either: (1) that she is mature enough and well enough informed to make her abortion decision, in consultation with her physician, independently of her parents' wishes; or (2) that even if she is not able to make this decision independently, the desired abortion would be in her best interests. The proceeding in which this showing is made must assure that a resolution of the issue, and any appeals that may follow, will be completed with anonymity and sufficient expedition to provide an effective opportunity for an abortion to be obtained. In sum, the procedure must ensure that the provision requiring parental consent does not in fact amount to the "absolute, and possibly arbitrary, veto" that was found impermissible in *Danforth*. *Ibid.*

443 U.S. at 643—44, 99 S.Ct. at 3048—49 (footnote omitted).

The Missouri procedure found in subsection 188.028.2(4) provides:

(4) In the decree, the court shall for good cause:

(a) Grant the petition for majority rights for the purpose of consenting to the abortion; or

(b) Find the abortion to be in the best interests of the minor and give judicial consent to the abortion, setting forth the grounds for so finding; or

(c) Deny the petition, setting forth the grounds on which the petition is denied.

The district court concluded that the statute was invalid because in (c) it allows the state court unbridled discretion to "deny the petition, setting forth the grounds on which the petition is denied," limited only by the requirement that the court has "good cause." 483 F.Supp. at 687—90.

[6] We would agree if the statute provides discretion to deny permission to a minor for *any* good cause it would violate the principles set forth in *Danforth* and *Bellotti II*. We believe, however, that in the context of the statutory language, a denial of the petition would initially require the court to find that the minor was not emancipated and was not mature enough to make her own decision and that an abortion was not in her best interests. These findings and the ultimate denial of the petition must be supported by a showing of "good cause". When the statute is so interpreted and applied it obviates Planned Parenthood's objections. Under these circumstances we find the judicial consent provision of the Missouri statute constitutional.

In view of the district court's finding that the judicial approval procedure was invalid the district court did not address Planned Parenthood's other objections to section 188.028. In the interest of judicial economy we do so now. First, Planned Parenthood points out that subsection 188.028.2(2) requires notice to all parents. It is argued that this is unconstitutional, relying on a statement in Justice Powell's opinion in *Bellotti II:*

> [E]very minor must have the opportunity—if she so desires—to go directly to court without first consulting or notifying her parents. If she satisfies the court that she is mature and well enough informed to make intelligently the abortion decision on her own, the court must authorize her to act without parental consultation or consent.

443 U.S. at 647, 99 S.Ct. at 3050.

The Supreme Court recently addressed this issue further in *H. L.* v. *Matheson,* ____ U.S. ____, 101 S.Ct. 1164, 67 L.Ed.2d 388 (1981). The Utah statute challenged in *Matheson* required the physician to "notify, if possible, the parents or guardian of the woman upon whom the abortion is to be performed, if she is a minor or the husband of the woman, if she is married." Utah Code Ann. § 76—7—304(2). *Matheson* holds that the state may require that notice be given to the parents of a minor who is living with and dependent upon her parents, is not emancipated by marriage or otherwise, and has made no claim or showing as to her maturity or her relations with her parents. *See* 101 S.Ct. at 1170. The Court narrowed its decision to these facts because the plaintiff "did not allege or proffer any evidence that either she or any member of her class is mature and emancipated." *Id.* at 1169.

Matheson establishes that the parental notice requirement in section 188.028 would be constitutional for minors like the plaintiff in that case. Our inquiry does not stop there, however. The standing of plaintiffs in this case is quite different from that of H. L. Here, plaintiffs are corporations and physicians who seek to provide abortion services. The complaint says that Planned Parenthood and Reproductive Health serve a patient population comprised of 36.5% and 16% of persons under 18, respectively. Plaintiffs have established that some of their patients include minors who are mature enough to make an abortion decision ("mature minors") or minors for whom an abortion without parental consultation is in their best interest ("best interests" minors). Although the complaint makes no specific claim in this respect, testimony of several plaintiffs indicates a desire to perform abortions for such individuals.[13] In general, these physicians agreed that notice requirements are a burden on availability of services, interfere with the doctor-patient relationship, and do not serve the best interests of the patients. In sum, the record makes it clear that these physicians deal with minors who they consider mature enough to make a decision without parental involvement, or for whom parental involvement is not in their best interests.

[7] We are thus faced with the question left open in *Matheson:* whether it is constitutionally permissible to require mature or "best interests" minors to notify their parents prior to a court hearing in which they seek judicial consent for an abortion. We have no need to analyze this problem at length, as the justices of the Supreme Court have already explored it. As noted, in *Bellotti II,* Justice Powell's opinion advances persuasive reasons for concluding that parental notice is unduly burdensome in cases involving mature or "best interests" minors. 443 U.S. at 642-48, 99 S.Ct. at 3047-51. In *H. L.* v. *Matheson,* Justices Powell and Stewart concurred in the decision, but insisted that "a State may not validly require notice to parents in all cases, without providing an independent decision-

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[13] *See* Widdicombe (Reproductive Health's Director) (T. 30-36, 74-78) (Reproductive Health identifies mature minors through screening process; some minors show greater maturity than persons of higher age); Palmer (T. 133-37) (some minor patients in his practice capable of giving informed consent without parental consent); Kassar (T. 216-19) (ability to give informed consent depends on factors other than age); Crist (T. 350-52) (presently provides abortions to women under 18 without parental involvement; believes many such women are capable of consent; cites example of "best interests" exception based on statistics showing 50% of those 12 years old and under who seek abortions are incest victims); Vera (T. 444-47) (psychiatrist who counsels women with unwanted pregnancies; personal experience includes instances where parental involvement has adverse effects).

maker to whom a pregnant minor can have recourse if she believes that she is mature enough to make the abortion decision independently or that notification otherwise would not be in her best interests." 101 S.Ct. at 1176—77. Justices Marshall, Brennan and Blackmun concluded that the Utah statute, which is very similar to the Missouri statute, is unconstitutional on its fact because the burdens it imposes exceed any identifiable state interests. *Id.* at 1184-94. The analysis in these opinions strongly suggests that subsection 188.028.2(2) is unconstitutional because it requires mature or "best interests" minors to give notice to their parents prior to the court hearing.[14] We so hold. *See also Wynn* v. *Carey,* 582 F.2d 1375, 1388 (7th Cir. 1978).

[8] Planned Parenthood also argues that several other features of section 188.028 are unconstitutional. They claim that the statute's supposed purpose of facilitating parental consultation is undermined by its overinclusiveness and underinclusiveness. They argue it is overinclusive because it requires the involvement of the parents of unemancipated minors who have been widowed or divorced and they argue that the statute is underinclusive because it does not require involvement of the parents of emancipated minors "regardless of their age, maturity, intelligence, education or experience...." While we acknoledge that the classification may not be perfect, we conclude emancipation is a sufficiently accurate indicia of dependence on parental advice to serve as the basis for a legislative judgment by the Missouri legislature.

Nonetheless, Planned Parenthood claims that "emancipated" is excessively vague. They refer to confusion among various witnesses about the meaning of the term. As will be more fully developed later in this opinion, we conclude that to conduct a criminal prosecution under this statute there must be proof of scienter as to the elements of the crime. A successful prosecution would require proof that the physician performing the abortion knew that a minor who received an abortion under subsection 188.028.1(2) was not "emancipated." Although the presence of a scienter requirement will not entirely eliminate problems caused by vagueness, we are satisfied it is sufficient here.[15] *See Colautti* v. *Franklin,* 439 U.S. 379, 395, 99 S.Ct. 675, 685-86, 58 L.Ed.2d 596 (1979).

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[14] Subsection 188.028.2(2) is severable from the remainder of the statute, so our holding does not affect the remainder of section 188.028.

[9] Planned Parenthood also claims that the statute does not assure that the procedure will be anonymous and expeditious.[16] We are satisfied that anonymity is sufficiently protected by these procedures, which do not require the minor to disclose her name. Furthermore, the statute sets forth reasonable time requirements for court action on the petition. Although the statute does no more than direct the Missouri Supreme Court to promulgate rules for expedited appellate review, we are confident the Missouri Supreme Court will exercise its jurisdiction in a manner that recognizes the serious dangers caused by delay.

We find the judicial consent provision under section 188.028 to be constitutional. We agree with Planned Parenthood, however, that the notice provisions found in subsection 188.028.2(2) are impermissible and must be set aside.

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[15] We note that the Missouri Supreme Court has considered the proof necessary to show emancipation in the context of parental tort liability. *See Wurth* v. *Wurth,* 322 S.W.2d 745, 746 (1959).

[16] The delay argument is based in part on the 48 hours of additional delay required by section 188.039. Since we conclude that it is unconstitutional to require a 48-hour delay, the potential for delay is reduced. See Part IV A, *infra.*

III. *Restrictions on Abortion after Viability.*

[10] The district court held that subsection 188.030.1 is unconstitutional because it allegedly imposes criminal liability for an erroneous but good faith determination that a fetus is nonviable. The district court also found subsections 188.030.2 and 188.030.3 unconstitutional on similar grounds. Further, subsection 188.030.2 was held unconstitutionally vague, and subsection 188.030.3's requirement of a second physician was held to be overbroad because it requires a second physician even when there is no reasonable chance of fetal survival.[17]

A. *Subsection 188.030.1: Mental Culpability Requirement*[18]

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[17] Missouri argues that none of the plaintiffs had standing to challenge section 188.030. The state relies on interrogatories submitted by the plaintiffs in which they said their abortion practices were limited to nonviable fetuses. However, at trial Dr. Kassar testified that he had once conducted an abortion at approximately 28 weeks, which is within the period of viability identified in *Roe* v. *Wade*. The district court found that this testimony established that "[e]nforcement of section 188.030 would have an immediate and direct effect on the medical practice of Dr. Kassar." In *Doe* v. *Bolton,* 410 U.S. 179, 93 S.Ct. 739, 35 L.Ed.2d 201 (1973), and *Planned Parenthood* v. *Danforth,* 428 U.S. 52, 62, 96 S.Ct. 2831, 2837, 49 L.Ed.2d 788 (1976), the Court recognized the standing of plaintiff physicians, since "[t]he physician is the one against whom these criminal statutes directly operate in the event he procures an abortion that does not meet the statutory exceptions and conditions." *Doe* v. *Bolton,* 410 U.S. at 188, 93 S.Ct. at 745. Since Dr. Kassar's credibility was a matter for the district court to resolve, and the district court accepted his testimony, he has standing. It is therefore unnecessary to determine whether other plaintiffs may also have standing.

[18] Subsection 188.030.1 reads:

> No abortion of a viable unborn child shall be performed unless necessary to preserve the life or health of the woman. Before a physician may perform an abortion upon a pregnant woman after such time as her unborn child has become viable, such physician shall first certify in writing that the abortion is

The district court based its holding that the State unconstitutionally imposed criminal liability without fault on *Colautti* v. *Franklin*, 439 U.S. 379, 99 S.Ct. 675, 58 L.Ed.2d 596 (1979).

In *Colautti* the Supreme Court said the Pennsylvania statute was unduly vague and that the vagueness was "compounded" by the fact the statute subjected a physician to liability without fault. The Court agreed that the Pennsylvania criminal code[19] required scienter as to "whether the physician's actions will result in the death of the fetus." *Id.* at 394, 99 S.Ct. at 685. However, it did not contain a requirement "that the physician be culpable in failing to find sufficient reason to believe that the fetus may be viable." *Id.* at 394-95, 99 S.Ct. at 685-86.

The district court acknowledge that subsection 188.030.1 does not have the vagueness problems encountered with the Pennsylvania law. However, it found that the Missouri law lacks a culpability requirement, and found that this alone rendered the statute unconstitutional. 483 F.Supp. at 692. Without a culpability requirement, the Missouri statute would create a "profound chilling effect on the willingness of physicians to perform abortions near the point of viability in the manner indicated by their best medical judgment." 439 U.S. at 396, 99 S.Ct. at 686.

> necessary to preserve the life or health of the woman and shall further certify in writing the medical indications for such abortion and the probable health consequences.

Mo.Ann.Stat. § 188.030.1 (Vernon).

[19] The Pennsylvania Act provided that a person who failed to make a viability determination or to exercise the prescribed standard of care was "subject to such civil or criminal liability as would pertain to him had the fetus been a child who was intended to be born and not aborted." Pa.Stat.Ann., Tit. 35, § 6605(a) (Purdon 1977). Criminal sanctions, if any, would be imposed under the separate Pennsylvania law of criminal homicide.

Missouri claims section 188.075 requires culpability as to viability:[20]

> Any person who contrary to the provisions of sections 188.010 to 188.085 *knowingly performs or aids in the performance of any abortion or knowingly fails to perform any action* required by sections 188.010 to 188.085 shall be guilty of a class A misdemeanor and, upon conviction, shall be punished as provided by law.

Mo.Ann.Stat. § 188.075 (Vernon) (emphasis added).

The district court acknowledged that section 188.075 requires a culpable mental state, but decided that like the Pennsylvania law in *Colautti,* it reaches only the act of abortion and not the viability determination.

We respectfully disagree with the district court's interpretation of the Missouri law. To violate section 188.075, one must do more than knowingly perform an abortion—one must knowingly perform an abortion that is contrary to subsection 188.030.1. Since the only abortions contrary to subsection 188.030.1 are abortions on viable unborn children, a physician could not knowingly perform an abortion contrary to subsection 188.030.1 unless he *knew* the child was viable. A good faith determination of nonviability would be a defense.

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[20] In the district court Missouri argued that the court should abstain and permit the state courts to construe this statute. Missouri has not argued for abstention on this appeal. We realize that "it would appear that abstention may be raised by the court *sua sponte.*" *Bellotti* v. *Baird,* 428 U.S. 132, 144 n.10, 96 S.Ct. 2857, 2864 n.10, 49 L.Ed.2d 844 (1976). Nonetheless, we see no reason to abstain here, since we find that the language of the Missouri statute clearly withstands the objections raised by Planned Parenthood. Furthermore, we note that Missouri has no certification procedure whereby this court can refer questions of state statutory construction to the state supreme court. *Cf. id.* at 150-51, 96 S.Ct. at 2867-68.

[11] This interpretation can also be reached by assuming that by using "knowingly" as it did, the Missouri legislature intended to describe the mental state required for all the crimes governed by section 188.075. However, because of the breadth of the acitivity covered by this penalty statute, the legislature was not precise as to the application of the mental state requirement to particular elements. Missouri has enacted, a statute to copy with this exact situation:

> If the definition of an offense prescribes a culpable mental state but does not specify the conduct, attendant circumstances or result to which it applies, the prescribed culpable mental state applies to each such material element.

Mo.Ann.Stat. § 562.021 (Vernon) (effective Jan. 1, 1979).

In this case, section 188.075 prescribes "knowingly" as the mental state, and Missouri statutes further define "knowingly":

> A person "*acts knowingly*", or with knowledge,
>
> (1) With respect to his conduct or to attendant circumstances when he is aware of the nature of his conduct or that those circumstances exist; or
>
> (2) With respect to a result of his conduct when he is aware that his conduct is practically certain to cause that result.

Mo.Ann.Stat. § 562.016.3 (Vernon).

As applied to the elements of this crime, the State would be required to prove that the physician was (1) aware he was performing an abortion; (2) aware this was a viable unborn child; and (3) aware the abortion was not necessary to preserve the life or health of the woman. When interpreted in this fashion, the statute does not impermissibly impinge on the rights of women and their physicians. It can be used to punish only those physicians who *know* that a fetus is viable and that the abortion is not necessary to the life and health of the woman. Such regulation is clearly permissible under *Roe*.

B. *Subsection 188.030.2.*

[12] The district court next considered subsection 188.030.2.[21] The court first found this section void for failure to require a culpable mental state. We again disagree with this interpretation; we conclude that the Missouri statutes require the State to prove culpability for the elements of this crime, just as they require proof under subsection 188.030.1. The State would have to prove, beyond a reasonable doubt: (1) that the doctor knew the child was viable; (2) that he knew the method he chose was not the available method most likely to preserve the life and health of the unborn child; and (3) that he knew the method he used was less or equally dangerous to the life and health of the woman than the available method most likely to preserve the life and health of the unborn child.

The district court also struck down this section of the Missouri law for unconstitutional vagueness. The court focused on the portion stating that the physician "may" use another technique when the technique that would be safest for the fetus presents "a greater risk to the life and health of the woman" than an available alternative.

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[21] Subsection 188.030.2 reads:

> Any physician who performs an abortion upon a woman carrying a viable unborn child shall utilize the available method or technique of abortion most likely to preserve the life and health of the unborn child. In cases where the method or technique of abortion which would most likely preserve the life and health of the unborn child would present a greater risk to the life and health of woman than another available method or technique, the physician may utilize such other method or technique. In all cases where the physician performs an abortion upon a viable unborn child, the physician shall certify in writing the available method or techniques considered and the reasons for choosing the method or technique employed.

Mo.Ann.Stat. § 188.030.2 (Vernon).

In *Colautti,* one of the criticisms of the Pennsylvania statute was that the choice of method to be utilized turned on whether an alternative was "necessary". 439 U.S. at 397-401, 99 S.Ct. at 686-689. The Missouri statute does not use this term. Instead, the choice of method turns on a direct balance of risk. If the risk to the woman from the "fetal survival method"[22] is *greater than* the risk to her from alternative methods, the physician *may* choose an alternative. Implicitly, if the risk to the woman from the fetal survival method is *less than or equal to* the risk to her from available alternative methods, the physician *must* use the fetal survival method. Given the precision of this balance, the question is not whether the statute is vague, but whether the woman's constitutional rights are violated by a requirement that a fetal survival method *must* be used whenever the risks to the woman with that method are less than or equal to the risk from other possible methods.[23]

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[22] This term is used here to refer to "the available method most likely to preserve the life and health of the unborn child." Mo.Ann.Stat. § 188.030.2 (Vernon).

[23] The district court emphasized that the statute says the physician "*may*" use another technique, implying that this inserts impermissible vagueness. However, the effect of the word "may" in this provision is this: when the risk to the woman of a fetal survival method is greater than the risk of available alternative methods, the physician *may* choose whatever method he wishes. In other words, when the risk of the survival method is greater, the statute leaves the doctor's choice exactly as it would be without the existence of this statute: to choose the method he deems appropriate. While this means he may choose the method that is more dangerous to the woman and safer for the fetus, the physician could have made a similar decision prior to passage of this statute; hence, the statute does nothing to alter the rights of the woman and her physician. We are aware of no decisions that have required the state to pass legislation *requiring* physicians to choose a method most favorable to the woman's life and health.

[13,14] The State has regulated post-viability abortions by requiring use of particular methods. This is clearly within the State's power, as long as it does not interfere with medical judgments as to the method necessary for the preservation of the life or health of the mother. *Roe* v. *Wade,* 410 U.S. at 164-65, 93 S.Ct. at 732-33. Thus, the Missouri statute is clearly constitutional in requiring use of a fetal survival method when the risks of that method to the woman are lower than alternatives. The only remaining question is whether the state can constitutionally require the use of the fetal survival method in cases where the risk is equal. By definition, if the risk is absolutely equal, the life and health of the mother are subjected to no greater risk by requiring use of the fetal survival method.[24] By requiring use of such a method when the risks from it are less than or equal to the risk of alternatives, Missouri is within permissible bounds of regulation.[25]

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[24] In discussing the Pennsylvania statute in *Colautti,* the Court observed that the statute "does not clearly specify, as appellants imply, that the woman's life and health must always prevail over the fetus' life and health when they conflict." 439 U.S. at 400, 99 S.Ct. at 688. This statement is in the context of a discussion of the vagueness of the statute, and merely rebuts a claim by Pennsylvania as to the specificity of the statute. *Colautti* did not hold that language of this nature is constitutionally required. Nor does it hold that a state may not require use of a method more likely to lead to fetal survival if the risks to the woman are equal. Even if this language were binding, by definition the woman's life and health and the fetus' life and health are not in "conflict" when the method favoring one's survival has no detriment to the chances of the other to survive.

[25] *Cf. Margaret S.* v. *Edwards,* 488 F.Supp. 181 (E.D.La.1980). The court held that a Louisiana statute was unconstitutional. It provided:

> Any physician who shall perform or induce an abortion upon a pregnant woman where the presumption of viability exists shall utilize the available method or technique of abortion most likely to preserve the life and health of the unborn child.

The court observed that this made no allowance for the life and health of the mother, as required by *Roe.* Here, of course, the statute allows the doctor to consider the life and health of the woman in choosing a method.

We have no disagreement with Planned Parenthood's argument that these are medical judgments that should not be second-guessed. However, if, as we have held, there is a culpability requirement, the State faces a stringent burden of proof as to the physician's actual knowledge of the viability of the child and the danger of the alternative methods. The State's power to regulate does not permit it to decide if a particular child is viable, or to choose a particular procedure, or to decide whether a procedure is necessary for the life and health of a particular woman. These decisions are left to physicians. The post-viability regulatory power does permit the State to criminalize abortions performed *after* a physician has made a judgment that a fetus is viable and the abortion or abortion method is not necessary for the life and health of the woman.

C. *Second Doctor Requirement.*

[15] The district court declared subsection 188.030.3[26] unconstitutional because of the lack of a culpability requirement. Again, we find that the Missouri statutes require culpability as to each material element of the crime.

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[26] Subsection 188.030.3 states:

> An abortion of a viable unborn child shall be performed or induced only when there is in attendance a physician other than the physician performing or inducing the abortion who shall take control of and provide immediate medical care for a child born as a result of the abortion. During the performance of the abortion, the physician performing it, and subsequent to the abortion, the physician required by this section to be in attendance, shall take all reasonable steps in keeping with good medical practice, consistent with the procedure used, to preserve the life and health of the viable unborn child; provided that it does not pose an increased risk to the life or health of the woman.

Mo.Ann.Stat. 188.030.3 (Vernon).

The district court also had another reason for striking down this section: the second physician requirement is overbroad because it requires a second physician even when the fetus has no reasonable chance of survival. Thus, the requirement is an "undue burden" in at least some cases. *See Charles* v. *Carey,* 627 F.2d 772 (7th Cir. 1980).

Review of this holding requires review of the support for the two underlying factual conclusions: (1) that the second physician requirement is a burden and (2) that there is no possible justification for a second physician during a D&E.

1. **Burden on Decision.**

[16] Missouri does not deny that costs are incrased by requiring a second physician, thereby retricting availability of the abortion.[27] Instead, Missouri argues that increased cost is not a direct burden. Missouri bases this argument on *Harris* v. *McRae,* 448 U.S. 297, 100 S.Ct. 2671, 65 L.Ed.2d 784 (1980), and other cases dealing with refusals by states or the federal government to make government funds available for abortions. *See also Williams* v. *Zbarz,* 448 U.S. 358, 100 S.Ct. 2694, 65 L.Ed.2d 831 (1980); *Maher* v. *Roe,* 432 U.S. 464, 97 S.Ct. 2376, 53 L.Ed.2d 484 (1977). However, Missouri's argument is not supported by these cases, which focus on the "basic difference between direct state interference with a protected activity and state encouragement of an alternative activity consonant with legislative policy." *Maher* v. *Roe,* 432 U.S. at 475, 97 S.Ct. at 2383. The state's refusal to pay for abortions is said not to be a "direct interference" because it "places no governmental obstacle in the path of a woman ...", *Harris* v. *McRae,* 100 S.Ct. at 2687, that is, the regulation does not create the woman's lack of finances, but merely fails to remedy it. In contrast, a government-imposed regulation that adds to the cost of abortion is a government-created obstacle and is subject to strict scrutiny. If the rule was as Missouri claims, the state would be free to add on any costly requirements under the guise of regulation, and would not be required to justify these requirements by a compelling state interest.

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[27] *E. g.,* Kassar (T. 226) (burden because requires presence of pediatrician for up to 24 hours); Crist (T. 354-57) (costs are increased by second physician requirement; conclusory statement it interferes with doctor-patient relationship); Kretzschmar (T. 394-95) (requiring second physician significantly increases cost; interferes with doctor-patient relationship and burdens availability).

It is apparent from even the conclusory testimony here that a second physician requirement would raise the cost of an abortion, thereby decreasing its availability and interfering with the decisions of some women to obtain abortions. Missouri did not challenge that proposition, and must justify its law with a compelling state interest.

2. *Justification for Second Physician During D&E.*

We move then to the argument that there is no possible justification for a second physician during a D&E procedure. Missouri claims there is no overbreadth in the second doctor requirement because doctors do not perform D&Es after viability. However, Dr. Crist testified (T. 427-29), with examples from his practice, that D&E may be the best medical practice at 28 weeks; he also testified that in the 60 days prior to his testimony he had done five post-24 week abortions by D&E. He chose this method because "there were absolutely contraindications to the use of hypertonic solutions or the use of prostaglandins, or the induction of labor." (T. 438).

[17,18] Missouri points to testimony by other physicians that they do not or would not use D&E at these stages. However, this serves only to indicate that the question is one in which medical opinions and circumstances may differ. There is no error in the district court's factual conclusion that for some patients and physicians, D&E is the method of choice even after viability is possible.[28]

The next question is whether the district court correctly concluded that a fetus cannot survive D&E. If the fetus could survive, the state may be able to require the presence of a second physician in furtherance of its compelling interest in the potential life of the fetus.

The D&E procedure is described in Tietze, Induced Abortion: 1979 (3d ed. 1979).

> When vaginal evacuation is performed in the second trimester, it typically involves use of a small forceps for the dismemberment and removal of the fetus, of a suction cannula for the aspiration of amniotic fluid and of placental and fetal debris, and of a surgical curette to ensure complete evacuation. To minimize the risk of laceration, laminaria is often used to dilate the cervix.

Id. at 68.

Several physicians said that dismemberment of the fetus is not always essential in a D&E procedure. However, Dr. Kassar indicated this was true of a smaller fetus; presumably, a viable fetus is larger. Several physicians testified that there was no chance a viable fetus would survive D&E.[29]

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[28] We note that the choice of D&E after viability is subject to the requirements of subsection 188.030.2. Thus D&E is not to be used when the child is viable and other methods are available that are more likely to preserve its life and health, and those methods do not pose a greater risk to the life and health of the woman than another available method or technique.

[29] *E. g.* Crist (T. 355) ("no chance"); Kretzschmar (T. 393); Nathanson (T. 615) (D&E never results in a live birth); Schmidt (T. 836) (no reason for second physician when D&E is used on viable fetus; no possibility of survival); Martin deposition, Defendant's Exhibit Q at 76-77 (live birth after D&E "an impossibility"). *See also* Kassar, (T. 258) (during second trimester, fetus is usually of sufficient size that skull must be crushed for D&E; chance of fetal survival in this type of procedure is "nil").

Missouri relies solely on Dr. Crist's testimony. Dr. Crist's testimony on cross-examination contradicted in part his earlier testimony, and did not specifically refer to a fetus that had reached viability. It was also contradicted by the overwhelming weight of testimony of doctors testifying for both sides. These experts all agreed that when D&E is performed on a viable fetus there is no change of survival, apparently because the fetus has reached a size where dismemberment is unavoidable. We conclude the district court's finding of fact as to the chances of survival is not clearly erroneous.

We agree with the district court that the second physician requirement is overbroad, and thus imposes a burden on women in cases where the burden is not justified by any possibility of survival of the fetus. We therefore affirm the district court's holding.[10]

IV. *"Informed Consent."*

Section 188.039 requires that the attending physician give a woman specific information prior to an abortion, and requires that 48 hours lapse between giving the information and the abortion. It also requires that the woman sign a consent form acknowledging that she has been given the required information.

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[10] In *Margaret S.* v. *Edwards,* 488 F.Supp. 181 (E.D.La.1980), the court discussed the constitutionality of a second physician requirement and concluded that such requirements were permissible, although the Louisiana statute imposed improper standards on the second physician. The court did not deal specifically with the D&E method, so its discussion was based on an evaluation of the chances of a live birth using any method. The court found that "the State can choose to be prepared for those rare instances when there is a live birth." *Id.* at 201. Nothing in this conclusion is in conflict with the result reached here. We do not reach the question of the state's right to require a second physician when there is some possibility the fetus may survive.

A. *48 Hour Wait.*

[19] The district court held that the 48 hour waiting requirement was unconstitutional, based on evidence that it increases delay, and delay increases the risk to the woman. Furthermore, it "requires that a woman make a minimum of two visits to her physician or to a clinic. This requirement involves additional time and expense and, for women living outside the metropolitan areas, may require additional travel or subsistence expense during the delay." 483 F.Supp. at 696. We affirm the ruling of this district court. *See Planned Parenthood League* v. *Bellotti,* 641 F.2d 1006, 1014-16 (1st Cir. 1981) (preliminary injunction against 24 hour wait); *Charles* v. *Carey,* 627 F.2d 772, 785-86 (7th Cir. 1980) (24 hours).[31]

B. *Notice to Parents of Minors.*

[20] Subsection 188.039.2 requires a minor to acknowledge that her parents have been given the information prescribed in section 188.039, and it forbids physicians to perform abortions unless the minor has so acknowledged. The district court held this provision unconstitutional on the grounds it was in contravention to the principles in *Bellotti II,* discussed in Part II, *supra.* On the basis of our discussion of *Bellotti II* and *H. L.* v. *Matheson* in Part II, *supra,* we agree that this requirement is also unconstitutional because it requires parental notice even when the minor is mature or emancipated or the abortion is in her best interests, and a court has made findings to that effect.

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[31] These findings are very similar to the district court's findings on this issue in *Women's Services* v. *Thone,* 483 F.Supp. 1022 (D.Neb. 1979). Based on these findings, the district court in Women's Services held the requirement unconstitutional, and this court affirmed. 636 F.2d 206, 210 (8th Cir. 1980). However, the entire decision in *Women's Services* was remanded to this court to reconsider in light of its recent decision in *H. L.* v. *Matheson,* ____ U.S. ____, 101 S.Ct. 1164, 67 L.Ed.2d 388 (1981). *Matheson* recognizes time is likely to be of the essence in an abortion decision. The Utah statute did not provide a mandatory waiting period.

C. *"Probable Physiological and Anatomical Characteristics of the Unborn Child" and "Physical Danger ... and Psychological Trauma".*

Subsection 188.039.2(3) requires the woman to acknowledge that she has been informed of "[t]he probable anatomical and physiological characteristics of the unborn child at the time the abortion is to be performed." Subsection 188.039.2(4) says she must be informed of "[t]he immediate and long-term physical dangers of abortion and psychological trauma resulting from abortion and any increased incidence of premature births, tubal pregnancies and stillbirths following abortion." The district court held these provisions unconstitutional. 483 F.Supp. at 698-99.

The Supreme Court allows the states to require "informed consent", even in the first trimester. *See Planned Parenthood* v. *Danforth,* 428 U.S. at 64-67, 96 S.Ct. at 2838-2840. Based upon that decision, courts have sustained various provisions designed to insure that the woman has made an informed consent. *See e. g., Wolfe* v. *Schroering,* 541 F.2d 523, 526 (6th Cir. 1976); *Planned Parenthood Association* v. *Fitzpatrick,* 401 F.Supp. 554, 587 (E.D.Pa. 1975), *aff'd,* 428 U.S. 901, 96 S.Ct. 3202, 49 L.Ed.2d 1205 (1976). *Cf. Planned Parenthood League* v. *Bellotti,* 641 F.2d at 1017-18 (state may require use of a specified form if physician is not required to read it or have it signed in office, or discuss it with the woman, and when physician may give any additional information).

Nonetheless, *Danforth* recognized that there are limits to what the state may require. The Court construed "informed consent" to mean:

> [T]he giving of information to the patient as to just what would be done and as to its consequences. To ascribe more meaning than this might well confine the attending physician in an undesired and uncomfortable straitjacket in the practice of his profession.

428 U.S. at 67 n.8, 96 S.Ct. at 2840 n.8.

The Court explained this further in ***Whalen*** v. ***Roe,*** 429 U.S. 589, 97 S.Ct. 869, 51 L.Ed.2d 64 (1977):

> The constitutional right vindicated in ***Doe*** [v. ***Bolton,*** 410 U.S. 179, [93 S.Ct. 739, 35 L.Ed.2d 201] (1973)] was the right of a pregnant woman to deicde whether or not to bear a child without unwarranted state interference. The statutory restrictions on the abortion procedures were invalid because they encumbered the woman's exercise of that constitutionally protected right by placing obstacles in the path of the doctor upon whom she was entitled to rely for advice in connection with her decision. If those obstacles had not impacted upon the woman's freedom to make a constitutionally protected decision, if they had merely made the physician's work more laborious or less independent without any impact on the patient, they would not have violated the Constitution.

Id. 429 U.S. at 605 n.33, 97 S.cCt. at 879 n.33.

Other abortion decisions emphasize the importance of the doctor/patient relationship to the abortion decision. ***See, e. g., Roe*** v. ***Wade,*** 410 U.S. 113, 164, 93 S.Ct. 705, 732, 35 L.Ed.2d 147 (1973); ***Doe*** v. ***Bolton,*** 410 U.S. 179, 196-97, 93 S.Ct. 739, 749-50, 35 L.Ed.2d 201 (1973); ***Colautti*** v. ***Franklin,*** 439 U.S. 379, 387-88, 99 S.Ct. 675, 681-82, 58 L.Ed.2d 596 (1979).

[21] In this context, we conclude that the state may not infringe on the ***woman's*** right to consult with a physician whose judgment and advice on the abortion decision has not been dictated by the state. Such a practice by the state may prevent the woman and the doctor from freely making the judgments left to them by ***Roe*** and subsequent decisions.

With this principle in mind, numerous courts have declared statutes unconstitutional which require physicians to give patients information contrary to their best judgment or medical opinions. *See Freiman* v. *Ashcroft,* 584 F.2d 247 (8th Cir. 1978), *aff'd,* 440 U.S. 941, 99 S.Ct. 1416, 59 L.Ed.2d 630 (1979); *Charles* v. *Carey,* 627 F.2d 772, 783-84 (7th Cir. 1980).[13] Most recently the First Circuit granted a preliminary injunction against a Massachusetts statute requiring "a description of the stage of development of the unborn child." The court found that information was immaterial to medically relevant considerations, and caused emotional distress. It also observed that many women did not want the information and their doctors considered it bad medical practice to force it on them. *Planned Parenthood League* v. *Bellotti,* 641 F.2d at 1021-23.

[22] We agree with the analysis in these cases, and the findings of the district court support similar conclusions here. The district court found that the "anatomical characteristics" and "physical dangers" information "interfere[s] with the right of a woman to consult with her physician regarding abortion free from state interference." 438 F.Supp. at 698. On the basis of repeated testimony it found that some physicians do not believe this information is in the best health interests of their patients, and that it may increase the risks from abortion by increasing the patient's anxiety and tension. Furthermore, some physicians testified they do not believe there are any long-term physical or psychological effects of abortion, or are unaware of such effects. Thus, "such physicians, in the exercise of their best medical judgment, would choose not to provide their patients seeking abortions with [the information]." *Id.* These findings demonstrate that there is a burden on the woman's decision: she is deprived of the freedom to make a decision in reliance on information provided by her physician based upon the physician's best medical judgment. Furthermore, the woman's decision is burdened insofar as the anxiety and tension involved in such a decision are increased without medical justification. There is no rational reason, much less a compelling state interest, that justifies forcing physicians to give women information that the physicians consider injurious to the woman's health or simply untrue. *See Planned Parenthood League* v. *Bellotti,* 641 F.2d at 1021-22. We affirm the district court's holding that subsections 188.039.2(3) and 188.039.2(4) are unconstitutional.

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[13] *See also Leigh* v. *Olson,* 497 F.Supp. 1340 (D.N.D.1980); *Margaret S.* v. *Edwards,* 488 F.Supp. 181, 210-11 (E.D.La.1980); *Akron Center for Reproductive Health* v. *City of Akron,* 479 F.Supp. 1172, 1203 (N.D.Ohio 1979); *Wynn* v. *Scott,* 449 F.Supp. 1302, 1316-17 (N.D.Ill.), *appeal dismissed,* 439 U.S. 8, 99 S.Ct. 49, 58 L.Ed.2d 7 (1978), *aff'd,* 599 F.2d 193 (7th Cir. 1979).

D. *Pregnancy and Time Elapsed Since Conception.*

Subsections 188.039.2(1) and 188.039.2(2) require the physician to tell the woman that in the physician's best medical judgment the woman is pregnant and the number of weeks elapsed since the probable time of conception. The district court found these requirements unconstitutional because they would prevent the procedure known as "menstrual extraction." Dr. Crist described this procedure as follows:

> Menstrual extracton, endometrical aspiration, and menstrual induction are all synonomous terms for aspiration or removal of uterine contents prior to the time that a classic urinary pregnancy test would turn positive, and that would be roughly four weeks after conception or 42 days after the last menstrual period.

T. 364-65.

The district court concluded that the physician cannot determine at this stage whether the woman is in fact pregnant. If a physician desired to perform this procedure with intent to cause an abortion, this statute would present the procedure because it would be impossible for the physician to give the woman the required information.

Missouri does not claim that a prohibition against menstrual extraction is constitutional, but argues here that the statute does not affect menstrual extraction because a menstrual extraction is not an abortion.[33] As the district court noted, Dr. Crist testified that it is a reasonable medical certainty that 85% of women with a menstrual period 10 days late are pregnant. Given this probability, it is entirely possible that a physician would perform the procedure with intent to terminate a pregnancy. During cross-examination, Dr. Palmer testified:

> Q. Have you ever performed a menstrual extraction intending to terminate the life of a fetus in his or her mother's womb?
>
> A. The intention of a menstrual extraction is either to correct a menstrual problem, which would would be a mini-D&C, or if the patient is pregnant and we can't detect it, it is an abortion.

So the answer to your question is yes. T. 193.

[23] The district court found that the present statutory language would prevent physicians from performing menstrual extractions since it is impossible to be certain that the woman is pregnant. We agree. Since there is no justification for such a prohibition, subsections 188.039.2(1) and (2) were properly declared unconstitutional.

E. *Attending Physician Must Give the Information.*

Section 188.039.1 requires that the "attending physician" inform the woman of the information described in subsection 188.039.2. The district court said this requirement is constitutional.

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[33] Abortion is defined under Missouri law as "the intentional desctruction of the life of an embryo or fetus in his or her mother's womb or the intentional termination of the pregnancy of a mother with an intention other than to incrase the probability of a live birth or to remove a dead or dying unborn child." Mo.Ann. Stat. § 188.015(1) (Vernon).

Planned Parenthood argues that the information can be given by non-physicians and that requiring physicians to give the information creates scheduling problems, delays, and high costs. They base this in part on their claim that "attending physician" refers to the same doctor who performs the operation.

[24] The delay and scheduling problems are not significant without the 48-hour waiting period. Similarly, the claims of higher cost and delay due to forcing a physician to spend up to an hour and a half giving this information have been undercut since the court has held several of these information requirements unconstitutional. The portions of subsection 188.039.2 that are not unconstitutional merely require the attending physician to inform the woman of the particular risks associated with the abortion technique to be used, and alternatives to abortion. The district court properly concluded that this minimal requirement is consistent with the principle that the abortion decision is one to be made by a woman and her physician,[34] and advances the state's interest in insuring that the decision is made with "full knowledge of its nature and consequences." *Planned Parenthood* v. *Danforth,* 428 U.S. at 67, 96 S.Ct. at 2840. *See Akron Center for Reproductive Health, Inc.* v. *City of Akron,* 479 F.Supp. 1172, 1204 (N.D.Ohio 1979); *Women's Community Health Center* v. *Cohen,* 477 F.Supp. 542, 550 (D.Me.1979).

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[34] Planned Parenthood emphasizes the problems raised by requiring that the same doctor give the information and perform the operation. It is by no means clear that the statute requires this. Subsection 188.039.1 says *no physician* shall perform an abortion unless *the attending physician* gave the required information. Subsection 188.039.2, which describes the information, refers exclusively to "the attending physician". Although it is not necessary to our holding, one could interpret this to mean that the *attending* physician must give the information, and that another physician may perform the operation. In contrast, in *Charles* v. *Carey,* the statute stated explicitly that the information must be given "by the physician who is to perform the abortion." 627 F.2d at 780 n.11. The court's declaration that this section was unconstitutional was based on the burdensomeness of this requirement.

V. *Pathology Reports.*

Section 188.047 requires:

> A representative sample of tissue removed at the time of aortion shall be submitted to board eligible or certified pathologist, who shall file a copy of the tissue report with the state division of health, and who shall provide a copy of the report to the abortion facility or hospital in which the abortion was performed or induced and the pathologist's report shall be made a part of the patient's permanent record.

Mo.Ann.Stat. § 188.047 (Vernon).

In upholding the constitutionality of this provision the court applied a rational basis test and found that the requirement was rationally related to the state's interest in the standards of medical care and was not an undue burden.

Planned Parenthood argues that this regulation burdens the woman's decision to obtain an abortion by increasing costs. The evidence showed this requirement would raise the cost of an abortion by $10 to $40.[35]

As we previously observed, *Harris* v. *McRae,* 448 U.S. 297, 100 S.Ct. 2671, 65 L.Ed.2d 784 (1980), and similar cases do not hold that imposition of additional costs cannot be a burden on the woman's decision. Section 188.047 applies to all abortions, including those performed in the first trimester. This court has previously discussed review of regulations imposed on those providing fir trimester abortions:

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[35] Judith Widdicombe, Executive Director of Reproductive Health, said the current cost of a first trimester abortion at Reproductive Health is $170, and estimated that this requirement would increase costs by $19.40/abortion (approximately 11.4%).

> [T]he state has the power to insure that the first trimester abortions, like other medical procedures, are performed under conditions providing for the maximum safety of the patient. Statutory provisions which merely authorize the adoption of regulations, albeit during the first trimester, are not unconstitution. *See Planned Parenthood Association* v. *Fitzpatrick,* 401 F.Supp. 554, 576 (E.D.Pa. 1975)....
>
> Any regulations promulgated under such enabling statutes must, of course, comply with the requirements of the Supreme Court. A state can impose the same regulations on a clinic, specifically built to perform abortions during the first trimester, that are imposed on other clinics that perform surgical procedures requiring approximately the same degree of skill and care as the performance of first trimester abortions. As long as the regulations applying to abortion clinics are the same as those applied to other clinics performing similar surgical procedures, it would not be impermissible to make them specifically applicable to abortion clinics. ***Where the state regulates abortions beyond its regulation of similar surgical procedures, that difference in treatment must be shown to be necessitated by the particular characteristics of the abortion procedure.*** *See Word* v. *Poelker, supra* at 1351-52.

Hodgson v. *Lawson,* 542 F.2d 1350, 1357-58 (8th Cir. 1976) (emphasis added, footnote omitted).

There was uncontroverted testimony that Missouri does not require submission of tissue to a pathologist following other medical procedures. Thus, the difference in requirements must be justified by the particular characteristics of the abortion procedure. As the Seventh Circuit stated in *Friendship Medical Center* v. *Chicago Board of Health,* 505 F.2d 1141 (7th Cir. 1974), *cert. denied,* 420 U.S. 997, 95 S.Ct. 1438, 43 L.Ed.2d 680 (1975):

> [T]he state will bear a heavy burden ... both with respect to showing the existence of a unique medical complication and with respect to showing that the problem is of such a nature as to be beyond the general scope of a doctor's professional judgment.[36]

Id. at 1154.

The issue here is not whether pathology reports are useful and even necessary in some cases. They clearly are. Testimony indicated that abnormalities in the tissue may warn of serious, possibly fatal disorders. Instead, the question here is whether Missouri has shown any rason why the physicians and medical facilities performing abortions cannot make medical judgments about the desirability of a pathology report in an individual case, while physicians and medical facilities performing all other types of surgery are free to exercise their professional judgment.

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[36] *See Planned Parenthood of Minnesota, Inc.* v. *Citizens for Community Action,* 588 F.2d 861 (8th Cir. 1977) (imposition of restrictive "zoning" ordinance on first trimester abortion facility); *Word* v. *Poelker,* 495 F.2d 1349 (8th Cir. 1974) (ordinance regulating first trimester abortion clinics). *See also Mahoning Women's Center* v. *Hunter,* 610 F.2d 456 (6th Cir. 1979), vacated and remanded, 447 U.S. 918, 100 S.Ct. 3006, 65 L.Ed.2d 1110 (1980) (ordinance requiring expensive equipment and supervision by experienced obstetrician); *Women's Medical Center of Providence, Inc.* v. *Cannon,* 463 F.Supp. 531 (D.R.I.1978) (requiring licensed physician with hospital privileges); *Florida Women's Medical Clinic, Inc.* v. *Smith,* 478 F.Supl. 233 (S.D.Fla.1979), *appeal dismissed,* 620 F.2d 297 (5th Cir. 1980) (various first trimester regulations unconstitutional, including pathologist requirement); *Arnold* v. *Sendak,* 416 F.Supp. 22 (N.D.Ind.), *aff'd,* 429 U.S. 968, 97 S.Ct. 476, 50 L.Ed.2d 579 (1976). *Cf. Baird* v. *Department of Public Health,* 599 F.2d 1098 (1st Cir. 1979) (abortion-neutral regulation of clinic licensing); *Abortion Coalition* v. *Michigan Department of Public Health,* 426 F.Supp. 471 (E.D.Mich.1977).

No proof sufficient to explain this distinction was offered by the State. Missouri relied on testimony indicating that some physicians, including pathologists, believe that it is good medical practice to have a pathologist examine any tissue removed from the body. These physicians also expressed concern that in a close case, a pathologist may see something that the ordinary physician would not. We accept this testimony as true, but these justifications do not distinguish tissue obtained from abortion from that obtained in every other surgical procedure. In procedures other than abortion, some physicians may say that every tissue should be examined and that nonpathologist physicians may err in close cases; further, the consequences to the patient of error may be serious. Nevertheless, in procedures other than abortion Missouri leaves it to the professional judgment of the physician to examine the tissue and decide whether a pathologist's examination and the additional costs it imposes are warranted. Physicians who perform aborions testified that they exercise their professional judgment. They routinely perform "gross' examinations of the tissue, and send it to the pathologist if their professional judgment so dictates.[37]

[25] In the absence of a more convincing justification for this distinction between first trimester abortion and other surgical procedures, we hold that the provision is unconstitutional.[38] We emphasize that this does not leave patients unprotected. Missouri law requires that all abortions be performed by physicians. As with any other surgical procedure, patients are protected by "the physician's medical judgment and professional, ethical standards and ... city and state health regulations which have application to [medical] procedures in general." *Word* v. *Poelker,* 495 F.2d 1849, 1351 (8th Cir. 1974). Patients are also protected by legal remedies for negligence of medical personnel.

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[37] A "gross" examination is one unaided by a microscope. Pathologists may perform a gross examination or a microscopic examination if they feel it is necessary. This statute does not specify which type of examination the pathologist is to perform. Dr. J. Chandler Smith, Chairman of the Pathology Department at the University of Missouri Medical School, testified that with respect to abortions, a non-pathologist physician is just as capable of performing an adequate gross examination as is a pathologist, and that the abnormalities which are of concern are readily identifiable.

VI. *Recordkeeping.*

Planned Parenthood challenges the constitutionality of subsection 188.052,2,[39] which deals with post-abortion care.

Planned Parenthood argues that many women will resist supplying the physician with the required information, particularly the time and place of the abortion. If the physician knowingly fails to complete the report, he or she is subject to criminal penalties. So, if a patient seeks the physician's services and refuses to give the required information, the physician can either treat her and risk criminal prosecution or refuse to care for her.

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[38] *Contra, Wynn* v. *Scott,* 449 F.Supp. 1302, 1322 (N.D.Ill.), *appeal dismissed,* 439 U.S. 8, 99 S.Ct. 49, 58 L.Ed.2d 7 (1978), *aff'd,* 599 F.2d 193 (7th Cir. 1979) (no burden on woman; plaintiff did not argue it burdened or discouraged patients).

[39] Subsection 188.052.2 provides:

> An individual complication report for any post-abortion care performed upon a woman shall be completed by the physician providing such post-abortion care. This report shall include:
>
> (1) The date of the abortion;
>
> (2) The name and address of the abortion facility or hospital where the abortion was performed;
>
> (3) The nature of the abortion complication diagnosed or treated.

Mo.Ann.Stat. § 188.052.2 (Vernon).

Neither the district court's opinion nor the Missouri defendants addressed this argument. In evaluating it, we observe that to subject this reporting requirement to strict scrutiny would be inappropriate here, as there are no suspect classifications and no fundamental rights at stake. Subsection two does not burden a woman's decision to seek an abortion, since it deals only with post-abortion care.[40] *See Whalen* v. *Roe,* 429 U.S. 589, 605 n.33, 97 S.Ct. 869, 879 n.33, 51 L.Ed.2d 64 (1977). Thus, this reporting requirement must only be rationally related to a constitutionally permissible purpose. Planned Parenthood is correct in arguing that the statute, on its face, does not state a defense for the physician if the patient refuses to provide information. Apparently Missouri feels that obtaining this information is of such importance that it must threaten the physician with criminal prosecution so that he or she will, in turn, threaten the woman with refusal of treatment. In view of the fact that the cause is to be remanded to the district court we defer judgment on this section until the district court has passed on the same. We therefore certify this issue back to the district court within the same time frame as the other issue certified.

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[40] It seems highly unlikely that a woman would forego a legal abortion for fear that in the event of complications she would have to tell a physician when and where she received the abortion.

VII. *Attorneys' Fees.*

The district court awarded $22,037.73 to plaintiffs' attorneys.[41] Missouri argues (1) Planned Parenthood did not "prevail" on every issue, since only five of eight challenged sections were partly invalidated; and (2) the district court included fees for travel time and clerical work. They focus mainly on the work done by the "second chair", Barbara Beran, that included taking notes on the testimony, which Missouri claims was "clerical" and not compensable at $60/hour. They also claim that travel time should not be compensated, or should be at a lower rate, and that travel was unnecessary because the suit would have been in St. Louis but for "forum-shopping" by the plaintiffs' attorney.

[26] The award of attorneys' fees should be based on the guidelines set forth in *Johnson* v. *Georgia Highway Express,* 488 F.2d 714, 717-19 (5th Cir. 1974), adopted by this Circuit. *See Crain* v. *City of Mountain Home,* 611 F.2d 726, 730 (8th Cir. 1979); *Zoll* v. *Eastern Allamakee Community School District,* 588 F.2d 246, 252 (8th Cir. 1978). The result obtained is only one factor to be considered, and it is not necessarily an abuse of discretion for the district court to award attorneys' fees based on all of the work performed and not just on the claims on which the plaintiffs were successful. "[A]ttorney's fees awarded under Section 1988 should not be limited to hours expended on those issues as to which the plaintiff was successful." *Crain* v. *City of Mountain Home,* 611 F.2d at 729 n.7. *See also Johnson* v. *Nordstrom-Larpenteur Agency,* 623 F.2d 1279, 1282 (8th Cir.), *cert. denied,* ____ U.S. ____, 101 S.Ct. 622, 66

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[41] Susman	148 hrs at $80/hr	$11,840.00
Beran	116.4 hrs at $60/hr	6,984.00
Shurin	7 hrs at $60/hr	455.00
Expenses		2,758.73
Total		$22,037.73

L.Ed.2d 504 (1980); *Brown* v. *Bathke,* 588 F.2d 634, 637 (8th Cir. 1978).

[27,28] There is no abuse of discretion in awarding attorneys' fees for a second counsel in a trial of this length and complexity. As for paying for travel time at the same rate as other activities, *Johnson* v. *Georgia Highway Express* indicates that the trial judge should consider whether the activity is legal work or other activity that could be accomplished by nonlawyers. Nonlawyers could not do the traveling for these attorneys; it was within the trial judge's discretion to award fees for the time consumed. Furthermore, the trial judge could have found that the hourly rate reflect inclusion of nonlegal activity.

The argument that the case could have been brought in the Eastern District of Missouri is frivolous. Venue was proper in the Western District and the plaintiffs' attorneys were free to choose the venue best suited to their clients' interests.

VIII. *Conclusion.*

We vacate the district court's finding that the requirement of hospitalization for second trimester abortions, under section 188.025, is unconstitutional. We remand this issue to the district court for further proceedings and findings as to whether the hospitalization requirement is a substantial burden on a woman's decision to have an abortion and, if so, whether the State has shown a compelling state interest which justifies the requirement.

We vacate the district court's finding that the provisions relating to parental or judicial consent contained in section 188.028 are unconstitutional in their entirety. Although we find the statute impermissibly requires notice to the parents of all minors, we find the judicial consent provision of the statute to be constitutional.

We reverse the district court's finding that section 188.030 of the Missouri statutes imposes strict criminal liability on doctors who abort viable fetuses. We find the Missouri law requires scienter (knowledge) by the physician such that it comports with constitutional requirements. We also reverse the district court's holding that subsection 188.030.2 is unconstitutionally vague.

Finally, we vacate the district court's holding sustaining the constitutionality of section 188.047, requiring pathology reports following all abortions. We find this requirement imposes an undue burden since there is no compelling state interest to justify it, at least in first trimester abortions.

We affirm the district court's finding that the requirement of a second doctor during an abortion of a viable unborn child pursuant to subsection 188.030.3 is unconstitutional. We likewise affirm the court's finding that a 48-hour waiting period as required by subsection 188.039.1 is unconstitutional.

We affirm the district court's finding that a portion of subsection 188.039.2 and all of subsections (1), (2), (3) and (4) thereunder are unconstitutional. These subsections require notice to parents of all minors and prescribe detailed information a doctor must give a woman seeking an abortion. The district court correctly upheld the right of the state to require the attending physician to inform the woman as to the particular medical risks associated with the abortion technique to be used and the available alternatives. We vacate the district court's finding that the state may require a physician to file post-abortion complication reports under section 188.052.2 and remand this provision for reconsideration in view of the argument made by the parties.

We affirm the award of attorneys' fees.

The cause is reversed in part and affirmed in part and remanded for further proceedings in accord with our directons. The district court should certify within 90 days its further findings regarding the constitutionality of sections 188.025 and 188.052.2. This court shall retain jurisdiction of this appeal until certification by the district court and further order of this court. Any petition for rehearing should be deferred until final judgment of this court; no mandate is to issue until final judgment is entered.

APPENDIX

AN ACT to repeal sections 188.015, 188.020, 188.025, 188.030, 188.035, 188.050, 188.055, 188.060, and 188.075, RSMo 1978, relating to regulation of abortions, and to enact in lieu thereof fifteen new sections relating to the same subject, with penalty provisions and an emergency clause.

Be it enacted by the General Assembly of the State of Missouri, as follows:

Section 1. Sections 188.015, 188.020, 188.025, 188.030, 188.035, 188.050, 188.055, 188.060 and 188.075, RSMo 1978 are repealed and fifteen new sections enacted in lieu thereof, to be known as sections 188.015, 188.020, 188.025, 188.027, 188.028, 188.030, 188.035, 188.037, 188.039, 188.047, 188.052, 188.055, 188.060, 188.063 and 188.075, to read as follows:

188.015. Unless the language or context clearly indicates a different meaning is intended, the following words or phrases for the purposes of sections 188.010 to 188.085 shall be given the meaning ascribed to them:

(1) "Abortion", the intentional destruction of the life of an embryo or fetus in his or her mother's womb or the intentional termination of the pregnancy of a mother with an intention other than to increase the probability of a live birth or to remove a dead or dying unborn child;

(2) "Abortion facility", a clinic, physician's office, or any other place or facility in which abortions are performed other than a hospital;

(3) "Conception", the fertilization of the ovum of a female by the sperm of a male;

(4) "Physician", any person licensed to practice medicine in this state by the state board of registration of the healing arts;

(5) "Unborn child", the offspring of human beings from the moment of conception until birth and at every stage of its biological development, including the human conceptus, zygote, morula, blastocyst, embryo, and fetus;

(6) "Viability", that stage of fetal development when the life of the unborn child may be continued indefinitely outside the womb by natural or artificial life-supportive systems.

188.020. No person shall perform or induce an abortion except a physician.

188.025. Every abortion performed subsequent to the first twelve weeks of pregnancy shall be performed in a hospital.

188.027. No abortion shall be performed except with the prior, informed and written consent freely given of the pregnant woman.

188.028. 1. No person shall knowingly perform an abortion upon a pregnant woman under the age of eighteen years unless:

(1) The attending physician has secured the informed written consent of the minor and one parent or guardian; or

(2) The minor is emancipated and the attending physician has received the informed written consent of the minor; or

(3) The minor has been granted the right to self-consent to the abortion by court order pursuant to subsection 2 of this section, and the attending physician has received the informed written consent of the minor; or

(4) The minor has been granted consent to the abortion by court order, and the court has given its informed written con-

sent in accordance with subsection 2 of this section, and the minor is having the abortion willingly, in compliance with subsection 3 of this section.

2. The right of a minor to self-consent to an abortion under subdivision (3) of subsection 1 of this section or court consent under subdivision (4) of subsection 1 of this section may be granted by a court pursuant to the following procedures:

(1) The minor or next friend shall make an applicaton to the juvenile court which shall assist the minor or next friend in preparing the petition and notices required pursuant to this secton. The minor or the next friend of the minor shall thereafter file a petition setting forth the initials of the minor; the age of the minor; the names and addresses of each parent, guardian, or, if the minor's parents are deceased and no guardian has been appointed, any other person standing in loco parentis of the minor; that the minor has been fully informed of the risks and consequences of the abortion; that the minor is of sound mind and has sufficient intellectual capacity to consent to the abortion; that, if the court does not grant the minor majority rights for the purpose of consent to the abortion, the court should find that the abortion is in the best interest of the minor and give judicial consent to the abortion; that the court should appoint a guardian ad litem of the child; and if the minor does not have private counsel, that the court should appoint counsel. The petition shall be signed by the minor or the next friend;

(2) Copies of the petition and a notice of the date, time, and place of the hearing shall be personally served upon each parent, guardian or, if the minor's parents are deceased and no guardian has been appointed, any other person standing in loco parentis of the minor listed in the petition by the sheriff or his deputy. If a parent or guardian or, if the minor's parents are deceased and no guardian has been appointed, any other person standing in loco parentis cannot be personally served within two days after reasonable effort, the sheriff or his deputy shall give

constructive notice to them by certified mail to their last known address and the hearing shall not be held for at least forty-eight hours from the time of the mailing. In any case where there exists the potential or appearance of conflict of interests between the parents or guardian or next friend of the child and the child, the court shall appoint a guardian ad litem to defend the minor's interests. The court shall set forth, for the record, the grounds for such appointment;

(3) A hearing on the merits of the petition, to be held on the record, shall be held as soon as possible within five days of the filing of the petition. If any party is unable to afford counsel, the court shall appoint counsel at least twenty-four hours before the time of the hearing. At the hearing, the court shall hear evidence relating to the emotional development, maturity, intellect and understanding of the minor; the nature, possible consequences, and alternatives to the abortion; and any other evidence that the court may find useful in determining whether the minor should be granted majority rights for the purpose of consenting to the abortion or whether the abortion is in the best interests of the minor;

(4) In the decree, the court shall for good cause:

(a) Grant the petition for majority rights for the purpose of consenting to the abortion; or

(b) Find the abortion to be in the best interests of the minor and give judicial consent to the abortion, setting forth the grounds for so finding; or

(c) Deny the petition, setting forth the grounds on which the petition is denied;

(5) If the petition is allowed, the informed consent of the minor, pursuant to a court grant of majority rights, or the judicial consent, shall bar an action by the parents or guardian of the minor on the grounds of battery of the minor by those performing the abortion. The immunity granted shall only ex-

tend to the performance of the abortion in accordance herewith and any necessary accompanying services which are performed in a competent manner. The costs of the action shall be borne by the parties.

(6) An appeal from an order issued under the provisions of this section may be taken to the court of appeals of this state by the minor or by a parent or guardian of the minor. The notice of intent to appeal shall be given within twenty-four hours from the date of issuance of the order. The record on appeal shall be completed and the appeal shall be perfected within five days from the filing of notice to appeal. Because time may be of the essence regarding the performance of the abortion, the supreme court of this state shall, by court rule, provide for expedited appellate review of cases appealed under this section.

3. If a minor desires an abortion, then she shall be orally informed of and, if possible, sign the written consent required by section 188.039 in the same manner as an adult person. No abortion shall be performed on any minor against her will, except that an abortion may be performed against the will of a minor pursuant to a court order described in subdivision (4) of subsection 1 of this section that the abortion is necessary to preserve the life of the minor.

188.030. 1. No abortion of a viable unborn child shall be performed unless necessary to preserve the life or health of the woman. Before a physician may perform an abortion upon a pregnant woman after such time as her unborn child has become viable, such physician shall first certify in writing that the abortion is necessary to preserve the life or health of the woman and shall further certify in writing the medical indications for such abortion and the probable health consequences.

2. Any physician who performs an abortion upon a woman carrying a viable unborn child shall utilize the available method or technique of abortion most likely to preserve the life and

health of the unborn child. In cases where the method or technique of abortion which would most likely preserve the life and health of the unborn child would present a greater risk to the life and health of the woman than another available method or technique, the physician may utilize such other method or technique. In all cases where the physician performs an abortion upon a viable unborn child, the physician shall certify in writing the available method or techniques considered and the reasons for choosing the method or technique employed.

3. An abortion of a viable unborn child shall be performed or induced only when there is in attendance a physician other than the physician performing or inducing the abortion who shall take control of and provide immediate medical care for a child born as a result of the abortion. During the performance of the abortion, the physician performing it, and subsequent to the abortion, the physician required by this section to be in attendance, shall take all reasonable steps in keeping with good medical practice, consistent with the procedure used, to preserve the life and health of the viable unborn child; provided that it does not pose an increased risk to the life or health of the woman.

188.035. Whoever, with intent to do so, shall take the life of a child aborted alive, shall be guilty of murder of the second degree.

188.037. No person shall use any fetus or child aborted alive for any type of scientific, research, laboratory or other kind of experimentation either prior to or subsequent to any abortion procedure except as necessary to protect or preserve the life and health of such fetus or child aborted alive.

188.039. 1. No physician shall perform an abortion unless, prior to such abortion, the physician certifies in writing that the woman gave her informed consent, freely and without coercion, after the attending physician had informed her of the information contained in subsection 2 of this section not less than forty-eight hours prior to her consent to the abortion, and shall further certify in writing the pregnant woman's age, based upon proof of age offered by her.

2. In order to insure that the consent for an abortion is truly informed consent, no abortion shall be performed or induced upon a pregnant woman unless she has signed a consent form that shall be supplied by the state division of health, acknowledging that she and, if she is a minor, her parent or legal guardian or person standing in loco parentis have been informed by the attending physician of the following facts:

(1) That according to the best medical judgment of her attending physician she is pregnant;

(2) The number of weeks elapsed from the probable time of conception of her unborn child, based upon the information provided by her as to the time of her last menstrual period and after a history and physician examination and appropriate laboratory tests;

(3) The probable anatomical and physiological characteristics of the unborn child at the time the abortion is to be performed;

(4) The immediate and long-term physical dangers of abortion and psychological trauma resulting from abortion and any increased incidence of premature births, tubal pregnancies and still births following abortion;

(5) The particular risks associated with the abortion technique to be used;

(6) Alternatives to abortion shall be given by the attending physician, including a list of public and private agencies and services that will assist her during her pregnancy and after the birth of her child.

3. The physician may inform the woman of any other material facts or opinions, or provide any explanation of the above information which, in the exercise of his best medical

judgment, is reasonably necessary to allow the woman to give her informed consent to the proposed abortion, with full knowledge of its nature and consequences.

188.047. A representative sample of tissue removed at the time of abortion shall be submitted to board eligible or certified pathologist, who shall file a copy of the tissue report with the state division of health, and who shall provide a copy of the report to the abortion facility or hospital in which the abortion-was performed or induced and the pathologist's report shall be made a part of the patient's permanent record.

188.052. 1. An individual abortion report for each abortion performed or induced upon a woman shall be completed by her attending physician.

2. An individual complication report for any post-abortion care performed upon a woman shall be completed by the physician providing such post-abortion care. This report shall include:

(1) The date of the abortion;

(2) The name and address of the abortion facility or hospital where the abortion was performed;

(3) The nature of the abortion complication diagnosed or treated.

3. All abortion reports shall be signed by the attending physician, and submitted to the state division of health within forty-five days from the date of the abortion. All complication reports shall be signed by the physician providing the post-abortion care and submitted to the division of health within forty-five days from the date of the post-abortion care.

4. A copy of the abortion report shall be made a part of the medical record of the patient of the facility or hospital in which the abortion was performed.

5. The state division of health shall be responsible for collecting all abortion reports and complication reports and collating and evaluating all data gathered therefrom and shall annually publish a statistical report based on such data from abortions performed in the previous calendar year.

188.055. 1. Every abortion facility, hospital, and physician shall be supplied with forms by the division of health for use in regards to the consents and reports required by sections 188.010 to 188.085. A purpose and function of such consents and reports shall be the preservation of maternal health and life by adding to the sum of medical knowledge through the compilation of relevant maternal health and life data and to monitor all abortions performed to assure that they are done only under and in accordance with the provisions of the law.

2. All information obtained by physician, hospital, or abortion facility from a patient for the purpose of preparing reports to the division of health under sections 188.010 to 188.085 or reports received by the division of health shall be confidential and shall be used only for statistical purposes. Such records, however, may be inspected and health data acquired by local, state, or national public health officers.

188.060. All medical records, reports, and other documents required to be kept under sections 188.010 to 188.085 shall be maintained in the permanent files of the abortion facility or hospital in which the abortion was performed for a period of seven years.

188.063. No abortion facility shall advertise or hold itself out as also providing counseling to pregnant women unless:

(1) The counseling is done by a licensed physician, registered nurse or other person holding at least a bachelor's degree from an accredited college or university in psychology or appropriate field or having completed special training in counseling;

(2) The counseling includes factual information given in such a manner as to not be misleading, including explicit disussion of the development of the unborn child; and

(3) The counseling includes a thorough disussion of alternatives to abortion and availability of agencies and services to assist her if she chooses to carry her child to term.

2. The prescribed course of study which shall constitute special training in counseling shall be promulgated by the division of health. Any rule or portion of a rule promulgated pursuant to this chapter may be suspended by the joint committee on administrative rules if after hearing thereon the committee finds that such rule or portion of the rule is beyond or contrary to the statutory authority of the agency which promulgated the rule, or is inconsistent with the legislative intent of the authorizing statute. The general assembly may reinstate such rule by concurrent resolution signed by the governor.

188.075. Any person who contrary to the provisions of sections 188.010 to 188.085 knowingly performs or aids in the performance of any abortion or knowingly fails to perform any action required by sections 188.010 to 188.085 shall be guilty of a class A misdemeanor and, upon conviction, shall be punished as provided by law.

Section A. Because of the necessity for immediate state action to regulate abortions to protect the lives and health of citizens of this state, this act is deemed necessary for the immediate preservation of the public health, welfare, peace and safety, and is hereby declared to be an emergency act within the meaning of the constitution, and this act shall be in full force and effect upon its passage and approval.

UNITED STATES COURT OF APPEALS
FOR THE EIGHTH CIRCUIT

Nos. 80-1130 and 80-1530

No. 80-1130.

Planned Parenthood Association of Kansas City,
Missouri, Inc.,
Naim S. Kassar, M.D.,
Reproductive Health Services,
Allen S. Palmer, D.O.,

Appellees,

v.

John Ashcroft, Attorney General of State of Missouri,
Ralph L. Martin, Prosecuting Attorney of Jackson
County, Missouri,

Appellants.

No. 80-1530.

Planned Parenthood Association of Kansas City,
Missouri, Inc.,
Naim S. Kassar, M.D.
Reproductive Health Services
Allen S. Palmer, D.O.,

Appellants,

v.

John Ashcroft, Attorney General of State of Missouri,
Ralph L. Martin, Prosecuting Attorney of Jackson
County, Missouri,

Appellees.

Submitted: November 17, 1980

Filed: November 30, 1981

Appeals from the United States District Court for the Western District of Missouri

Supplemental Opinion to 655 F.2d 848.

Before LAY, Chief Judge, HENLEY, Circuit Judge, and HARRIS,* Senior Judge.

LAY, Chief Judge.

This supplemental opinion is necessitated by reason of our previous certification to the district court relating to two issues. In our original opinion, we vacated the district court's finding that the hospitalization requirement for second trimester abortions, under section 188.025 of the Missouri statutes, is unconstitutional. We remanded that issue to the district court for further proceedings and findings as to whether the hospitalization requirement is a substantial burden on a woman's decision to have an abortion and, if so, whether the state has shown a compelling state interest which justifies the requirement. We also vacated the district court's finding that the state may require a physician to file postabortion complication reports under section 188.152.2 and remanded this provision for reconsideration in view of the argument made by the parties.

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* Oren Harris, Senior District Judge, Eastern and Western Districts of Arkansas, sitting by designation.

In accord with our certification the district court took additional evidence[1] and made further findings regarding the statute's hospitalization requirements for all second trimester abortions.[2]

The district court, the Honorable Elmo B. Hunter presiding, found: (1) only one hospital in Missouri currently performs second trimester dilatation and evacuation (D&E) procedures; (2) second trimester D&E procedures performed in a hopsital are generally significantly more expensive than the same procedures performed in an outpatient facility; and (3) requiring all second trimester abortions to be performed in a hospital results in fewer second trimester procedures being performed than if hospitalization was not required. As a result, the district court found the second trimester D&E procedure, the safest post-12 week abortion technique currently available, is an alternative which is not available to many pregnant women in Missouri. On this basis Judge Hunter found that section 188.025 creates a substantial interference with and imposes a direct burden on a woman's decision to have an abortion.

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[1] Further evidence was taken on these issues in a hearing conducted on August 6-7, 1981. At that hearing, plaintiffs elicited testimony from Judith A. Widdicombe, President and Executive Director of Reproductive Health Services; Wayne Schramm, Director of the Bureau of Health Data Analysis of the Missouri Division of Health; Dr. Stanley Henshaw, Senior Research Associate at the Alan Guttmacher Institute; and Dr. Samuel G. Eubanks, Jr., a board certified specialist in the fields of obstetrics and gynecology. Defendants presented no testimony at this hearing, but at its conclusion did introduce into evidence the deposition of Dr. Willard Cates, taken on July 21, 1981, in Atlanta, Georgia. The deposition of Dr. Cates was duly received by the court.

[2] Section 188.025 states:

Every abortion performed subsequent to the first twelve weeks of pregnancy shall be performed in a hospital.

Mo. Ann. Stat. § 188.025 (Vernon).

I. Second Trimester Hospitalization Requirement.

Section 188.025 requires that second and third trimester abortions be performed in a hospital. Mo. Ann. Stat. § 188.025 (Vernon). If state legislation creates substantial interference with and imposes a direct burden on a woman's decision to have an abortion, then the state requirement is to be evaluated to determine if it reasonably relates to the state's interest in maternal health. *Roe* v. *Wade,* 410 U.S. 113, 164 (1973); *Planned Parenthood Ass'n* v. *Ashcroft,* 655 F.2d 848, 854 (8th Cir. 1981).

This court concluded previously, and additional evidence presented to the district court reinforces the conclusion, that D&E is the most used and safest procedure for second trimester abortion. *Ashcroft,* 655 F.2d at 855.

At the original trial of this action, the district court concluded that second trimester D&E was available only in one hospital in Missouri. That conclusion rested solely on the personal knowledge of two physicians, neither of whom testified that he was familiar with the policies of the hospitals throughout the state. However, evidence presented at the evidentiary hearing persuasively corroborates the district court finding.[3] The state did not dispute that any hospital other than Truman Medical Hospital has performed or is willing to perform second trimester abortions using the D&E procedures.

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[3] Wayen Schramm, the Director of the Bureau of Health Data Analysis for the Missouri Center for Health Statistics, testified that in 1981 his office began to record second trimester abortions by the D&E method. Only one hospital reported performing any second trimester abortions by the D&E procedure. This is the same hospital, Truman of Kansas City, reported in the previous proceedings before the court.

Stanley Henshaw, Senior Research Associate at the Alan Guttmacher Institute, which collects and analyzes abortion statistics on a state-by-state basis, testified that in 1979 and 1980, three hospitals reported one or more second trimester abortions by any method. The Kansas City hospital did more than 99 per cent of all second trimester abortions in those two years. One hospital reported one second trimester abortion in each of those two years; the other reported three abortions in each of the two years. He testified that the Institute inferred that those latter two hospitals are not really making abortion services available to women given the infrequency of second trimester abortions at those two hospitals.

The record demonstrates that hospitalized D&E's are more expensive than nonhospitalized D&E's. There exists evidence that some hospitalized second trimester D&E procedures are twice as expensive as nonhospitalized D&E procedures.[4] The district court concluded from the evidence that requiring hospitalized second trimester abortions places a financial burden on many women seeking such abortions.[5] On the basis of the record presented, this finding is not clearly erroneous.

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[4] Dr. Samuel G. Eubanks, Jr., a practicing physician in Louisville, Kentucky, specializes in obstetrics and gynecology. He practices in an office that has performed 15,500 abortions since 1976; he personally has performed approximately 1,400 second trimester D&E's. He testified that in Kentucky the average cost of a nonhospitalized second trimester abortion was about one-half the cost of what it would be in the hospital

In the original proceedings, witnesses testified that the increase in the cost burden to the woman of obtaining second trimester D&E's in hospitals, rather than clinics, runs from $150.00 to $1,650.00.

[5] During the period when all second trimester abortions were required to be performed in hospitals, 540 procedures were performed. In 1980, when that requirement was removed, the total number of second trimester procedures performed in Missouri was 1,390, 700 of which were performed in hospitals and 690 of which were performed in outpatient facilities. Dr. Henshaw testified that Missouri met only 13 per cent of the perceived need for second trimester abortions in the state in 1979; however, it met 34 per cent of the perceived need in 1980. In 1980, there were two second trimester abortion providers in the state, Truman Medical Hospital of Kansas City and Reproductive Health Services of St. Louis, a clinic. In 1979, only Truman Medical Hospital provided second trimester abortions. Dr. Henshaw would not infer that Reproductive Health Services substantially met all the need for second trimester abortions in the St. Louis area. Dr. Henshaw also testified that nationally 9 per cent of all abortions performed were second trimester abortions. In 1979, 3.4 per cent of all abortions performed in Missouri were second trimester abortions, but in 1980, when abortions could be performed in outpatient clinics, the figure was 6.9 per cent.

Since section 188.025 creates a substantial interference with and imposes a direct burden on a woman's decision to have an abortion, the state has the burden of showing that Missouri's requirement reasonably relates to the protection of the woman's health. As we stated in our previous decision, the state must show that nonhospitalized D&E procedures can reasonably be considered more dangerous than hospital procedures, including hospitalized D&E. *Ashcroft*, 655 F.2d at 856.

The central issue is the relative safety of nonhospitalized D&E and hospitalized methods. No quantitative studies are cited which directly compare the relative safety of the two procedures. However, the district court has found explicitly that a nonhospitalized second trimester D&E procedure is just as safe as those second trimester D&E procedures conducted in hospitals.[6] Since the district court's finding is not clearly er-

---

Dr. Eubanks also testified that the higher cost of hopsitalized second trimester D&E procedures placed a financial burden on many patients seeking abortions.

[6] We are aware of the Sixth Circuit's decision in *Akron Center for Reproductive Health, Inc.* v. *City of Akron*, 651 F.2d 1198 (6th Cir. 1981). In *Akron*, the plaintiffs tried to show that because of the D&E procedure, abortion through the 17th or 18th week of pregnancy is safer than childbirth. Thus, they argued that, under *Roe* v. *Wade*, the state's interest in maternal health does not become compelling before that time and the requirement that all second trimester abortions be performed in hospitals is unconstitutionally overbroad.

In the district court, the plaintiffs presented evidence that early second trimester clinical abortions were just as safe as second trimester abortions performed in hospitals. The district court, however, did not find plaintiff's evidence so convincing that it was willing to discard the Supreme Court's formulation in *Roe* v. *Wade*.

The Sixth Circuit noted that two district courts held that the state's interest in the health of the pregnant woman does not become compelling until the 18th week of pregnancy. *Margaret* v. *Edwards*, 488 F. Supp. 181, 194-96 (E.D. La. 1980) and *Planned Parenthood Ass'n* v. *Ashcroft*, 483 F. Supp. 679, 687 (W.D. Mo. 190). The Sixth Circuit found the rationale of these decisions persuasive. However, it also found that, by affirming *Gary-Northwest Indiana Women's Services,* roneous, we find that nonhospitalized second trimester D&E procedures are no more dangerous to maternal health than hospitalized procedures. Consequently, we hold that section 188.025 is not reasonably related to maternal health and, therefore, the requirement that *all* second trimester abortions be performed in hospitals is unconstitutional. *See Planned Parenthood* v. *Danforth,* 428 U.S. 52, 76 (1976).

II. **Recordkeeping.**

Subsection 188.052.2 of the Missouri statutes requires physicians to complete individual complication reports concerning postabortion care that they provide.[7] Plaintiffs argue that a

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Inc. v. *Bowen,* 496 F. Supp. 894, 896-902 (N.D. Ind. 1980), *aff'd sub nom. Gary-Northwest Indiana Women's Services, Inc.* v. *Orr,* ____ U.S. ____, 101 S.Ct. 2012 (1981), the Supreme Court had an opportunity to retreat from the "bright line" drawn in *Roe* v. *Wade* and declined to do so. Thus, it affirmed the district court's holding that the statute was constitutional.

Evidence adduced at the original trial in this cause and the evidentiary hearing suggests that the nonhospitalized procedures may actually be safer. The evidence cited in the original opinion is noted by this court in *Ashcroft,* 655 F.2d at 857 n.12. At the evidentiary hearing, Dr. Willard Cates, Chief of the Abortion Surveillance Branch of the Family Planning Evaluation Division at the Center for Disease Control, stated that in his opinion D&E procedures through 16 weeks after the last menstrual period (14 weeks after conception) are just as safe in outpatient facilities as they are in hospitals. The district court views the testimony of Dr. cates to say that section 188.025 prevents D&E procedures, particularly in the 15th and 16th weeks after the last menstrual period. Also, the district court concluded that, even though testimony tended to show that hospitals are better equipped to treat postabortion infections, such infections do not occur until 24 to 72 hours after the procedure is completed. By that time a patient will have been dismissed from either a hospital or an outpatient facility.

[7] Subsection 1889.052.2 states:

> An individual complication report for any post-abortion care performed upon a woman shall be completed by the physician providing such postabortion care. This report shall include:

physician may be faced in completing these reports with the situation where the patient will not or cannot provide the necessary information. Plaintiffs argue that the physician is then faced with the dilemma of filing a report with incomplete date, thereby subjecting himself to criminal liability, or refusing to treat the patient.

The district court was not convinced that a reasonable interpretation of subsection 188.052.2 would place physicians in the dilemma envisioned by plaintiffs. The court interprets the statute to require physicians to complete the reports using data that is reasonably available to them. That interpretation is shared by the Missouri attorney general. Since physicians are required only to report information that is reasonably available to them, section 188.052.2 does not place physicians in the dilemma of refusing treatment to patients or subjecting themselves to criminal liability by filing an incomplete report when the patient refuses to or cannot provide date to be included in the postabortion complication report.

The reporting requirement is not subject to strict scrutiny analysis, as there are no suspect classifications or fundamental rights at stake. The reporting requirement need only be rationally related to a constitutionally permissible purpose. The district court, finding that the reporting requirements are consistent with the holding of *Planned Parenthood* v. *Danforth, supra,* ruled that it is rationally related. The requirements of subsection 188.052.2 provide the state with information that is helpful to

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(1) The date of the abortion;

(2) The name and address of the abortion facility or hospital where the abortion was performed;

(3) The nature of the abortion complication diagnosed or treated.

Mo. Ann. Stat. § 188.052.2 (Vernon).

medical assistance, judgments, and medical standards. Thus, it is also reasonably related to the state's interest in protecting maternal health. *Connecticut* v. *Menillo,* 423 U.S. 9, 10-11 (1975); *Roe* v. *Wade,* 410 U.S. at 164.[8]

III. Conclusion

We affirm the district court's finding that the requirement of hospitalization for second trimester abortions under section 188.025 is unconstitutional. We affirm the district court's finding that a state may require a physician to file postabortion complication reports under subsection 188.052.2. These rulings shall be incorporated into our prior judgment, *Planned Parenthood Ass'n* v. *Ashcroft,* 655 F.2d 848 (8th Cir. 1981), and the integrated judgment as not amended shall issue.

It is so ordered.

A true copy.

Attest:

CLERK, U. S. COURT OF APPEALS,
EIGHTH CIRCUIT.

---

[8] Dr. Cates testified that keeping the type of statistics mandated by the statute has been shown to contribute to the safety of abortion procedures.

Joint Appendix

Office - Supreme Court, U.S.
FILED
JUL 26 1982
ALEXANDER L. STEVAS,
CLERK

Nos. 81-1255 and 81-1623

IN THE

Supreme Court of the United States

OCTOBER TERM, 1981

PLANNED PARENTHOOD ASSOCIATION OF KANSAS CITY,
MISSOURI, INC., NAIM S. KASSAR, M.D., REPRODUCTIVE
HEALTH SERVICES AND ALLEN S. PALMER, D.O.,
Petitioners and Cross-Respondents,

vs.

JOHN ASHCROFT, ATTORNEY GENERAL OF THE STATE
OF MISSOURI, AND RALPH L. MARTIN, PROSECUTING ATTORNEY
OF JACKSON COUNTY, MISSOURI,
Cross-Petitioners and Respondents.

On A Writ Of Certiorari To The United States
Court of Appeals For The Eighth Circuit

JOINT APPENDIX

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NOTE ON PRIOR OPINIONS

The initial opinion of the District Court on January 23, 1981 is reported at 483 F.Supp. 679 (W.D.Mo. 1980) and is reprinted in the Petition for Certiorari (No. 81-1255) at A-1 through A-51.

The interlocutory opinion of the Court of Appeals on July 8, 1981 is reported at 655 F.2d 848 (8th Cir. 1981) and is reprinted in the Petition for Certiorari (No. 81-1255) at A-52 through A-108.

The supplemental and final opinion of the Court of Appeals on November 30, 1981 is reported at 664 F.2d 687 (8th Cir. 1981) and is reprinted in the Petition for Certiorari (No. 81-1255) at A-109 through 117.

Nos. 81-1255 and 81-1623

In The

Supreme Court of the United States

October Term, 1981

Planned Parenthood Association Of Kansas City,
Missouri, Inc., Naim S. Kassar, M.D., Reproductive
Health Services And Allen S. Palmer, D.O.,
Petitioners and Cross-Respondents,

vs.

John Ashcroft, Attorney General Of The State
Of Missouri, And Ralph L. Martin, Prosecuting Attorney
Of Jackson County, Missouri,
Cross-Petitioners and Respondents.

On A Writ Of Certiorari To The United States
Court of Appeals For The Eighth Circuit

JOINT APPENDIX

RELEVANT DISTRICT COURT DOCKET ENTRIES

Date	**Proceedings**
1979	
June 30	Complaint filed. Summons waived. MOTION FOR TRO. $15.00 P.
June 30	TRO issued restraining defts. from enforcing . . . Mo.R.S. §§ 188.020, 188.025, 188.028. 188.030, 188,039, 188.047, 188.052, 188,063 and 188.075 till further order of this Court. EBH
July 20	Answer filed by deft. John Ashcroft

July 30	Answer by deft. Ralph L. Martin.
Sept. 27	Order modifying TRO by deleting §§188.020, 188.025 & 188.075 RSMo. EBH
1980	
Jan. 16	Opinion & Order - The following portions of the 1979 Missouri act relating to the regulation of abortions are hereby declared to be unconstitutional: §188.025, §188.028, §188.030, portions of §188.039 and §188.063. No injunctive order will issue at this time.
Jan. 16	Judgment on decision by the court.
Jan. 24	Motion by pltfs. to amend judgment, w/affidavit by Frank Susman in support of motion for award of attorney's fees.
May 7	Order awarding pltfs' attorneys' fees in the amount of $19,279. plus their expenses in the amount of $2,758.73, for a total award of $22,037.73. EBH
June 6	Notice of Appeal filed by defts. (no filing fee)
June 18	Notice of Cross-Appeal filed by plfts.
July 21	Bill of Costs in the amount of $111.45, taxed.
1981	
Oct. 2	Opinion on Remand this Court concludes that the reporting requirements of Sec. 188.052.2 are rationally related to a constitutionally permissable purpose. This action is hereby certified to the 8th Circuit Court of Appeals for further consideration. EBH

1982

Jan. 4	Notice by U.S. Supreme Court of filing petition for certiorari.
March 23	Bill of cost filed by pltf. $1,268.60

RELEVANT COURT OF APPEALS DOCKET ENTRIES

1981

July 8	Interlocutory Opinion filed
Nov. 30	Final Opinion and Judgment filed
Dec. 2	Motion and Affidavit of Appellees/Cross-Appellants for Fees and Costs filed

1982

Jan. 19	Suggestions of Appellants/Cross-Appellees in Opposition to Motion of Appellees/Cross-Appellants for Fees and Costs filed
March 12	Order as to Award of Fees and Costs

IN THE UNITED STATES DISTRICT COURT FOR THE
WESTERN DISTRICT OF MISSOURI
CENTRAL DIVISION

No. 79-4142-CV-C

Planned Parenthood Association of Kansas City,
Missouri, Inc., *et al.*,
Plaintiffs,

v.

John Ashcroft, *et al.*,
Defendants.

PLAINTIFFS' MOTION AND SUGGESTIONS IN SUPPORT THEREOF TO AMEND JUDGMENT, PURSUANT TO FEDERAL RULE OF CIVIL PROCEDURE No. 52(b)

(Filed January 24, 1980)

COME NOW Plaintiffs and pursuant to Federal rule of Civil Procedure No. 52(b), move this Court to amend its "Opinion and Order" herein entered on January 16, 1980, by the inclusion therein of an order awarding to Plaintiffs their reasonable attorneys' fees and costs herein incurred. Plaintiffs have expressly prayed for such additional relief in paragraph 34 of their Verified Complaint filed herein on June 30, 1979, pursuant to 42 U.S.C., §1988.

Attorneys' fees have consistently been awarded in similar cases. See: *Finney* v. *Hutto,* 548 F.2d 740, 742-743 (8th Cir. 1977), *affirmed,* 437 U.S. 678 (1978), 57 L.Ed.2d 522; *Gay Lib* v. *The University of Missouri,* 558 F.2d 848, 857 (8th Cir. 1977), *cert. denied,* 434 U.S. 1080 (1978); *Planned Parenthood of Minnesota, Inc.* v. *Citizens for Community Action,* 558 F.2d 861, 870-871 (8th Cir. 1977); *Wharton* v. *Knefel,* 562 F.2d 550, 557

(8th Cir. 1977); *Simpson* v. *Weeks,* 570 F.2d 240, 244 (8th Cir. 1978); *Pickett* v. *Milam,* 579 F.2d 1118, 1120-1121 (8th Cir. 1978); and *Reproductive Health Services* v. *Freeman,* ____ F.Supp. ____ (No. 77-4171-CV-C, W.D.Mo., January 26, 1979), *affirmed in part, reversed in part,* ____ F.2d ____ (Nos. 79-1275 and 79-1346, 8th Cir., January 9, 1980) (Slip Opinion at pp. 30-31).

The standards of this Court for such awards is clear. *They should be awarded unless special circumstances render such an award unjust.*

> "The 1976 Act tracks the statutory authorization for attorney's fees contained in Title II of the Civil Rights Act of 1964, 42 U.S.C. §2000a-3(b), which was expansively construed by the Supreme Court in *Newman* v. *Piggie Park Enterprises, Inc.,* 390 U.S. 400, 88 S.Ct. 964, 19 L.Ed.2d 1263 (1968): a plaintiff successful in asserting his rights under Title II 'should ordinarily recover an attorney's fee unless special circumstances would render such an award unjust.' *Newman, supra,* at 402, 88 S.Ct. at 966. The ample legislative history of the 1976 Act shows that Congress intended this liberal standard to control a fee award under the new statute. The Senate report on the bill ultimately enacted into law specifies the *Newman* standard as the touchstone for an award under the 1976 Act:
>
>> It is intended that the standards for awarding fees be generally the same as under the fee provisions of the 1964 Civil Rights Act. A party seeking to enforce the rights protected by the statutes covered by [the Civil Rights Attorney's Fees Award Act of 1976], if successful, 'should ordinarily recover an attorney's fee unless special circumstances would render such an award unjust.' *Newman* v. *Piggie Park Enterprises, Inc.,* 390 U.S. 400, 402 [88 S.Ct. 964, 19 L.Ed.2d 1263] (1968).

> S.Rep. No. 94-1011, 94th Cong., 2d Sess. 4 (1976), *reprinted in* [1976] U.S. Code Cong. & Adm. News. pp. 5908, 5912 (footnote omitted)." *Wharton, supra,* 562 F.2d at 557. Similarly, is *Planned Parenthood of Minnesota, Inc., supra,* 558 F.2d at 870 and *Pickett, supra,* 579 F.2d at 1120.

Plaintiffs suggest that no such special circumstances exist here. Plaintiffs have diligently borne a burden on behalf of all physicians, their patients and other citizens of this State to force compliance by Defendants with the established law. Plaintiffs should not be forced to bear alone the expenses of this litigation and this action clearly falls within the intent and purview of 42 U.S.C. §1988. Plaintiffs attach hereto a supporting Affidavit.

Accordingly, Plaintiffs pray that this Court award to them their reasonable attorneys' fees, expenses and costs incurred in this cause to date of $22,460.88, as per the Affidavit attached hereto.

Respectfully submitted,

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IN THE UNITED STATES DISTRICT COURT FOR THE WESTERN DISTRICT OF MISSOURI CENTRAL DIVISION

No. 79-4142-CV-C

Planned Parenthood Association of Kansas City,
Missouri, Inc., *et al.*,
Plaintiffs,
v.
John Ashcroft, *et al.*,
Defendants.

ORDER

(Filed May 7, 1980)

On April 23, 1980, a full evidentiary hearing was held on plaintiffs' motion for award of attorneys' fees pursuant to 42 U.S.C. § 1988. The evidence presented at that hearing and the affidavits submitted by counsel for plaintiffs support a finding that plaintiffs' attorneys expended the hours listed below in the prosecution of this action. The Court finds that the services rendered, including that in the presence of the Court, were consistent with the hourly rates specified.

Frank Susman	148 hours at $80 per hour	$11,840
Barbara Beran	116.4 hours at $60 per hour	6,984
Leland Shurin	7 hours at $65 per hour	455
Total		$19,279

The Court further finds that the evidence supports an award of $2,758.73 in out-of-pocket expenses.

Accordingly, plaintiffs are hereby awarded their attorneys' fees in the amount of $19,279 plus their expenses in the amount of $2,758.73, for a total award of $22,037.73.

IT IS SO ORDERED.

Elmer B. Hunter
United States District Judge

IN THE UNITED STATES DISTRICT COURT FOR THE
WESTERN DISTRICT OF MISSOURI
CENTRAL DIVISION

No. 79-4142-CV-C-H

Planned Parenthood Association of Kansas City,
Missouri, Inc., et al.,
Plaintiffs,

v.

John Ashcroft, Attorney General of the State of Missouri,
et al.,
Defendants.

OPINION ON REMAND

(Filed October 2, 1981)

This action pends before the District court on remand from the Eighth Circuit Court of Appeals for the purpose of taking additional evidence and making further findings in accordance with the opinion of the appellate court concerning the 1979 Missouri statute (the Act) relating to the regulation of abortions.[1] Specifically, this Court is to make further findings regarding the statute's hospitalization requirement for all second trimester abortions[2] and to consider arguments not previously considered by this Court or the defendants regarding the constitutionality of the recordkeeping requirements of subsection 188.052.2, R.S.Mo.[3]

---

[1] Planned Parenthood Association of Kansas City, Missouri, Inc. v. Ashcroft, Nos. 80-1130 and 80-1530, slip op. (8th Cir. July 8, 1981).

[2] Section 188.025, R.S.Mo., states:

> Every abortion performed subsequent to the first twelve weeks of pregnancy shall be performed in a hospital.

Further evidence was taken on these issues in a hearing conducted on August 6-7, 1981. At that hearing, plaintiffs elicited testimony from Judith A. Widdicombe, President and Executive Director of Reproductive Health Services; Wayne Schramm, Director of the Burearu of Health Data Analysis of the Missouri Division of Health; Dr. Stanley Henshaw, Senior Research Associate at the Alan Guttmacher Institute; and Dr. Samuel G. Eubanks, Jr., a Board Certified Specialist in the fields of obstetrics and gynecology. Defendants presented no testimony at this hearing, but at its conclusion did introduce into evidence the deposition of Dr. Willard Cates, taken on July 21, 1981, in Atlanta, Georgia. The deposition of Dr. Cates was duly received by the Court.

Second Trimester Hospitalization Requirement

In its opinion remanding portions of this action for further consideration, the appellate court has directed that it should be determined if section 188.025 creates substantial interference with and imposes a direct burden on a woman's decision to have an abortion. If this issue is resolved in the affirmative, then the hospitalization requirement of the statute should be evaluated to determine if it reasonably relates to the state's interest in maternal health. *Roe* v. *Wade,* 410 U.S. 113 (1973).

---

[3] Subsection 188.052.2 states:

> An individual complication report for any post-abortion care performed upon a woman shall be completed by the physician providing such post-abortion care. This report shall include:
>
> (1) The date of the abortion;
>
> (2) The name and address of the abortion facility or hospital where the abortion was performed;
>
> (3) The nature of the abortion complication diagnosed or treated.

In initially determining if section 188.025 creates a substantial interference with and imposes a direct burden on the decision of a woman to have an abortion, the appellate court suggests further findings on the issues of (1) the availability of hospitalized second trimester dilatation and evacuation (D & E) procedures in the State of Missouri, (2) the relative expense of hospitalized D & E procedures, and, (3) the effect the hospitalization requirement of section 188.025 has had on the number of second trimester abortions performed in Missouri. From these findings, this Court will address the issue of whether the second trimester hospitalization requirement creates a substantial interference with and imposes a direct burden on a woman's decision to have an abortion.

Should this issue be determined in favor of the plaintiffs, this Court must then determine if the hospitalization requirement is reasonably related to the State's interest in maternal health. Here, the bruden is on the State to "show that nonhospitalized D & E [procedures] can reasonably be considered more dangerous than hospital procedures, including hospitalized D & E. It must also show that the methods that it argues are as safe or safer than hospitalized D & E are actually available to Missouri women."[4] With these standards in mind, this Court will carefully consider the evidence adduced at the trial of this action, together with the evidence presented at the August 6-7, 1981, hearing.

Availability Of Second Trimester D & E Procedures

In its original opinion, this Court concluded that the D & E abortion procedure was the safest of the presently available post-twelve (second trimester) abortion techniques.[5] No evidence to the contrary has subsequently been presented to the Court and there is no reason to disturb this original finding. Having concluded that the D & E procedure is the safest second trimester abortion technique currently available, the Court's attention turns to the actual availability of that technique to women in the State of Missouri.

---

[4] *See* note 1, *supra,* at 11.

[5] 483 F.Supp. at 686.

At the original trial of this action, the uncontroverted evidence indicated that there is only one hospital in the state which performs second trimester abortions by the D & E technique.[6] That testimony was corraborated and further substantiated at the evidentiary hearing conducted by this Court.[7] This Court remains convinced that second trimester D & E procedures are currently performed in only one hospital in Missouri.

In addition to the one hospital which performs second trimester abortions by the D & E method, only two other hospitals in the state reported performing any second trimester abortions in 1979 and 1980.[8] The state introduced no evidence to show that any hospital in Missouri, other than the one already mentioned, is performing second trimester abortions by the D & E method. Further, there was no evidence to indicate that any other hospital in the state is ready, willing or able to perform second trimester abortions using the D & E procedure.

---

[6] *Id.* at 686, n. 14

[7] Wayne Schramm, the Director of the Bureau of Health Data Analysis for the Missouri Center for Health Statistics, a section of the Missouri Department of Health, testified that since his office began keeping statistics on the number of hospitals in Missouri performing second trimester abortions by the D & E method (beginning in 1981) only one hospital has reported performing any second trimester abortions by the D & E procedure. The identity of that hospital corresponds with the identity of the hospital reported in the previous proceedings before this Court.

[8] The testimony of Dr. Stanley Henshaw, Senior Research Associate of the Alan Guttmacher Institute, indicated that one hospital performed one second trimester abortion in each of the years 1979 and 1980, and one hospital reported performing three second trimester abortions in each of the years 1979 and 1980. None of these abortions were performed by the D & E method.

The testimony at both the original proceeding and the supplementary hearing clearly indicated that the relative expense of a second trimester abortion by the D & E method is greater when the procedure is performed in a hospital than when the same procedure is performed in a clinic. Performing second trimester D & E procedures in hospitals, rather than clinics, increases the cost burden to the patient by $150.00 to as much as $1650.00.[9] These figures do not represent how much a hospitalized second trimester D & E procedure costs, but rather they represent how much *more* such a procedure costs than when it is performed in a clinic. Further, the testimony of Dr. Samuel G. Eubanks, Jr.,[10] at the supplemental evidentiary hearing was to the effect that hospitalized second trimester D & E procedures are twice as expensive as nonhospitalized D & E procedures.[11] He concluded that the higher cost of hospitalized second trimester D & E procedures placed a financial burden on many patients seeking such abortions.

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[9] See testimony of Judith A. Widdicombe (Tr. 22), Dr. Allen S. Palmer (Tr. 130), and Dr. Robert Crist (Tr. 347) in the original proceeding. Ms. Widdicombe testified that hospitalization increased the cost burden to the patient by $150.00 to $750.00. Dr. Palmer testified that hospitalization increased the cost burden by $1,000.00 to $1,650.00. Dr. Crist testified that hospitalization increased the cost burden by $1,350.00 to $1,500.00.

[10] Dr. Eubanks is a practicing physician in Louisville, Kentucky, specializing in obstetrics and gynecology. He has extensive experience in the performing of abortions in both hospitals and in out patient facilities.

[11] Dr. Eubanks testified that a hospitalized second trimester D & E procedure costs approximately $800.00 to $1,000.00. Ms. Widdicombe testified that the average cost of a second trimester D & E abortion at the plaintiff Reproductive Health Service Clinic is about $260.00.

This Court finds that the expense of obtaining a second trimester D & E abortion in a hospital is significantly greater than that of obtaining the same procedure in an out patient facility. Thus, requiring all second trimester abortions to be performed in a hospital places a financial burden on many women seeking such abortions.

During the time that section 188.025 was in effect in Missouri, primarily 1979, it was required that all second trimester abortions be performed in hospitals. During that period, the total number of second trimester abortion procedures performed was 540.[12] In 1980, when second trimester abortions could be performed in both hospitals and out patient facilities, the total number of second trimester procedures performed in Missouri was 1390, 700 of which were performed in hospitals and 690 of which were performed in out patient facilities.[13] In 1979, when second trimester abortions could only be performed in hospitals, Dr. Henshaw testified that Missouri was meeting 13% of the perceived need for second trimester abortions in the state.[14] Alternatively, in 1980, when second trimester abortions could be and were performed in both hospitals and out patient facilities, 34% of the perceived need for second trimester abortions in Missouri was met.

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[12] See testimony of Dr. Stanley Henshaw. Dr. Henshaw further testified that, in 1980, when both hospitals and out patient facilities could perform second trimester abortions, the number of second trimester abortions performed by hospitals did not decrease, but rather increased.

[13] These figures are rounded to the nearest ten.

[14] See the testimony of Dr. Henshaw at the supplementary evidentiary hearing (Tr. 74-75) for an explanation of the significance and method of calculating perceived for second trimester abortions.

On the record before it, this Court is convinced that requiring that all second trimester abortions be performed in a hospital resulted in the performance of fewer second trimester procedures than if the hospitalization requirement was not in effect.[15]

Summary

The evidence before this Court indicates, and this Court finds, that (1) only one hospital in Missouri currently performs second trimester D & E procedures, (2) that second trimester D & E procedures performed in a hospital are generally significantly more expensive than the same procedures performed in an out patient facility and that this greater expense places a financial burden on the decision of many women who seek abortions by use of the D & E method, and, (3) requiring all second trimester abortions to be performed in a hospital results in fewer second trimester procedures being performed than if hospitalization were not required. These finding lead this Court to conclude, as it did in its original opinion, that the requirement that all second trimester abortions be performed in a hospital has the practical effect of making a second trimester D & E procedure, the safest post-twelve week abortion technique currently available, an alternative which is unavailable to many pregnant women in Missouri. As a result, section 188.025 creates a substantial interference with and imposes a direct burden on a woman's decision to have an abortion.

---

[15] In 1979, when second trimester abortions were only allowed in hospitals, 3.4% of all abortions performed in Missouri were second trimester procedures. This compared with a national average of 9%. In 1980, when second trimester abortions could be and were performed in both hospitals and out patient facilities, 7.9% of all abortions performed in Missouri were second trimester procedures. See testimony of Dr. Stanley Henshaw.

Reasonableness Of Section 188.025

Having concluded that section 188.025 creates a substantial interference with and imposes a direct burden on the decision of a woman to have an abortion, the state is faced with the burden of showing that the hospitalization requirement of section 188.025 reasonably relates to the state's interest in maternal health. As the appellate court suggests, this burden requires the state, in order to prevail, to show that nonhospitalized second trimester D & E procedures can reasonably be considered more dangerous than hospitalized second trimester D & E procedures. In connection with this burden, it should be noted that the only additional evidence produced by the state on the remand of this action was the introduction of the deposition of Dr. Willard Cates, whose deposition was noticed by plaintiffs. That evidence has been carefully weighed and considered by this Court in reaching its conclusions.

The testimony before this Court indicates that no quantative studies have been published which directly compare the relative safety of hospitalized second trimester D & E procedures versus nonhospitalized second trimester procedures.[16] However, based on the record before it, this Court is convinced that non hospitalized second trimester procedures are at least as safe as hospitalized second trimester procedures. There is no convincing evidence that a non hospitalized second trimester D & E procedure is more dangerous to maternal health than those second trimester D & E procedures conducted in hospitals.

Testimony in the original proceeding from one of defendants' experts indicated that the mortality and morbidity rates for D & E procedures performed outside a hospital were probably no different than those performed in a hospital.[17] At the supplemental evidentiary hearing, Dr. Eubanks testified that in his medical opinion, based on his extensive experience with abortions in both hospitals and in out patient clinics, second trimester procedures are properly categorized as minor surgery which is appropriate for an out patient facility, and in fact, it is Dr. Eubanks' opinion that D & E procedures conducted in an out patient facility are safer than those same procedures conducted in hospitals.[18] This opinion is further supported by the deposition testimony of Dr. Willard Cates, Chief of the Abortion Surveillance Branch of the Family Planning Evaluation Division at the Center for Disease Control. It is Dr. Cates' opinion that D & E procedures performed in nonhospital settings appear to have no greater risk than those performed in hospitals and that it is no safer to perform D & E procedures in hospitals than it is to perform them in out patient facilities.[19]

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[16] See testimony of Dr. Samuel G. Eubanks, Jr.

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[17] 483 F.Supp. at 686, n. 12.

[18] Dr. Eubanks based his opinion in large part on the conclusion that hospitalization increases the anxiety of the patient, hospitalization increases the risk of infection because more serious strains of infections are found in hospitals than are found in out patient facilities, and the travel time and distance necessary to reach a hospital may adversely affect the patient. Ms. Widdicombe, Dr. Naim S. Kassar and Dr. Crist also testified, in the original proceeding, that hospitals generally use general anesthesia in procedures of this type more often than out patient facilities do, thereby ultimately increasing the risk to the patient.

[19] The state challanges the weight of Dr. Cates' testimony on the grounds that he testified that D & E procedures performed in an out patient facility are just as safe as those done in a hospital when performed 13-15 weeks after the last menstrual period. This, the state suggests, is consistent with section 188.025. The Court disagrees. The state argues that section 188.025, when read in conjunction with 188.015 (3), only requires abortions to be performed in a hospital after the 12th week from the date of conception, which is comparable to the 14th week from the last menstrual period. Thus, according to the state, the statute only requires abortions subsequent to the 12th week

The record does not contain sufficient evidence to convince this Court that second trimester D & E procedures performed in out patient facilities are any more dangerous than second trimester D & E procedures performed in hospitals.[20] The state has not satisfied its burden of proof in this regard.[21] On the contrary, the weight of the evidence leads this Court to conclude that second trimester D & E procedures performed at out patient facilities are just as safe as those procedures performed in hospitals. Consistent with the analysis applied in its original opinion, together with the reasoning of the Supreme Court in *Planned Parenthood* v. *Danforth,* 428 U.S. 52 (1976), the state's limitation of second trimester abortions to hospitals cannot stand as a reasonable regulation for the protection of maternal health.[22]

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after conception or the 14th week after the last menstrual period to be performed in a hospital. However, Dr. Cates' testimony, at pages 80 and 119, of his deposition, clearly indicates that it is his opinion that D & E procedures through 16 weeks after the last menstrual period (14 weeks after conception) are just as safe in out patient facilities as they are in hospitals. The Court views the testimony of Dr. Cates as saying that section 188.025 prevents D & E procedures, particularly in the 15th and 16th weeks after the last menstrual period (13th and 14th weeks after conception). The state's argument in this regard is rejected.

[20] Even though the testimony tended to show that hospitals are better equipped to treat post-abortion infections, such infections do not occur until 24 to 72 hours after the procedure is complete. By that time a patient will have been dismissed from either a hospital or out patient facility. See testimony of Ms. Widdicome.

[21] Further, the state has not satisfied its burden of showing that methods which it argues are as safe or safer than nonhospitalized D & E procedures are actually available to Missouri women.

[22] 483 F.Supp. at 686.

Recordkeeping

Subsection 188.052.2 of the Act requires that physicians complete individual complication reports concerning post-abortion care they provide. Specifically, these reports include the date of the abortion, the name and address of the facility performing the abortion, and the nature of the complication diagnosed or treated by the physician providing the post-abortion care.

In completing these reports a physician may be faced with the situation where the necessary data is not within the personal knowledge of the physician[23] and the patient has refused to provide the data or for some reason cannot.

Plaintiffs argue that when a physician does not possess the data sought by the report, many women will resist supplying the data to the physician. Thus, plaintiffs suggest, the physician is faced with the dilemma of filing a report with incomplete data, thereby subjecting himself to criminal liability,[24] or refusing to care for a patient who refuses or cannot provide the required data. The case has been remanded to this Court for consideration of this argument. This Court is not convinced that a reasonable interpretation of subsection 188.052.2 would place physicians in the dilemma envisioned by plaintiffs.

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[23] It is clear that data concerning the nature of the complication treated or diagnosed would always be within the personal knowledge of the physician. The only data which might not be available to the physician, if he was not the physician who performed the abortion, would be the date of the abortion and the identity of the facility where the abortion was performed.

[24] The potential liability of a physician for failure to comply with section 188.052.2 is provided for in section 188.075, R.S.Mo.:

> Any person who contrary to the provisions of sections 188.010 to 188.085 knowingly performs or aids in the performance of any abortion or knowingly fails to perform any action required by sections 188.010 to 188.085 shall be guilty of a class A misdemeanor and, upon conviction, shall be punished as provided by law.

Even though subsection 188.052.2 does not provide, on its face, a defense for physicians if the patient refuses to or cannot provide necessary data, physicians should not have to fear criminal liability in situations such as those described by plaintiffs.

A reasonable interpretation of the statute, and the one adopted by this Court, requires physicians to complete the reports using data that is reasonably available to them. This interpretation of the statute is, in fact, shared by the attorney general of the State of Missouri[25] who, along with other state and county prosecutors, is charged with enforcing the statute.[26] Interpreted in this manner, a physician does not knowingly violate the requirements of the statute, and thus subject himself to criminal liability, when he is unable to provide data requested by the report because the patient refuses or cannot supply it and it is not otherwise within the personal knowledge of the physician. In such situations it is clear to this Court that a physician has no intent or culpable state of mind to thwart the reporting requirements of the statute.[27]

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[25] Although the opinion of the attorney general is not binding upon this Court, it is persuasive authority in determining how a statute of the State of Missouri should be interpreted.

[26] "That statute (§188.052.2) requires a physician treating a post-abortion complication to file a report including the necessary information only to the extent that the patient being treated is able and willing to supply the necessary information. Further, section 188.052.2 requires a treating physician to fill out an individual complication report only to the extent that the required information is made available to the physician." Defendants' Supplemental Brief on Remand at 6.

[27] "If his patient refuses to supply him with information, then the physician can hardly be interpreted as having an intent to violate the law. He has done everything within his power to comply with the law and treat his patient." Defendants' Supplemental Brief on Remand at 6.

This Court interprets section 188.052.2 to require that physicians complete individual post-abortion complication reports with the data that is reasonably available to them. A physician does not knowingly violate section 188.052.2 by filing a report which does not include the date of the abortion or the identity of the facility performing the abortion if that data is not within his personal knowledge and the patient refused or cannot provide it. This interpretation is consistent with both the intent of the State of Missouri, as expressed by the attorney general, and with the actions of the state to date.[18] Section 188.052.2, as read by this Court, does not place physicians in the dilemma of refusing treatment to patients or subjecting themselves to criminal liability by filing an incomplete report when the patient refuses or cannot provide data to be included in the post-abortion complication report.

It should be noted that even if the State of Missouri attempts to hold a physician criminally liable for failing to include data on section 188.052.2 reports because the patient refused to or could not provide it, the physician may then challenge the constitutionality of the statute as it is applied to him individually. However, in light of this Court's holding today regarding the interpretation of section 188.052.2, it is not necessary to reach that issue at this time.

As noted by the appellate court, section 188.052.2 reporting requirements deal with post-abortion care and, as such, do not burden a woman's decision to seek an abortion in the first place.[29] Thus, the appropriate standard for judging the validity of the reporting requirements is whether they are rationally related to a constitutionally permissable purpose.[30]

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[18] Testimony at the Supplemental evidentiary hearing on August 6-7, 1981, from Mr. Wayne Schramm indicated that since the post-abortion complication reports referred to in section 188.052.2 had been required, 53 such reports had been filed with the state. Of those 53 reports, 6 did not include the name and address of the facility performing the abortion. None of these incomplete reports have been referred to either the Missouri Attorney General or any other state or county prosecutor for further action.

As in its original opinion, this Court remains convinced that the reporting requirements of this section are consistent with the holding in *Planned Parenthood* v. *Danforth, supra.* The requirements of this section provide the state with information which, among other things, is related to the state's interest in maternal health, *Roe* v. *Wade, supra,* and may provide a resource that is relevant to medical experience, judgment, and the maintenance of medical standards.[31] *State of Connecticut* v. *Mellino,* 423 U.S. 9 (1975). Compilation by the state of the particular post-abortion complication information required by this section may ultimately lead to safer medical procedures in the future. Further, all recordkeeping and reporting required by the statute is to remain confidential and be used only for statistical purposes.[32] This Court concludes that the reporting requirements of section 188.052.2 are rationally related to a constitutionally permissable purpose.

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[29] Slip op. at 44.

[30] *Id.*

[31] The testimony of Dr. Willard Cates, taken by deposition, indicated that the ethical considerations involved in abortion procedures places abortions in the unique category of a surgical procedure with intense public interest focused upon it. Dr. Cates concluded that placing abortions in this unique category warrants keeping the type of statistics which have been shown to add to the safety and document the safety of abortion procedures.

[32] 483 F.Supp. at 700, n. 50.

In accordance with the findings of this opinion, this action is hereby certified to the Eighth Circuit Court of Appeals for further consideration.

IT IS SO ORDERED.

/s/ Elmer B. Hunter
SENIOR UNITED STATES
DISTRICT JUDGE

IN THE
UNITED STATES COURT OF APPEALS
FOR THE EIGHTH CIRCUIT

Nos. 80-1130 & 80-1530

Planned Parenthood Association of Kansas City,
Missouri, Inc., *et al.*,
Appellees/Cross-Appellants,

v.

John Ashcroft, *et al.*,
Appellants/Cross-Appellees.

MOTION AND AFFIDAVIT IN SUPPORT THEREOF OF APPELLEES/CROSS-APPELLANTS FOR ATTORNEYS' FEES AND COSTS, PURSUANT TO EIGHTH CIRCUIT RULE NO. 17

(Filed December 2, 1981)

Come now Appellees/Cross-Appellants and pursuant to Eighth Circuit Rule No. 17 file their Motion and Affidavit in support thereof for attorneys' fees and costs incurred during the appellate process of these appeals.

1. Affiant has acted as chief cou;nsel for Appellees/Cross½Appellants throughout the entire course of this litigation.

2. Affiant is experienced in the field of abortion law, having litigated numerous abortion related cases before various federal District Courts, various federal Circuit Courts and several of these cases before the United States Supreme Court.

3. Affiant during the course of these appeals has expended the following time on behalf of Appelles/Cross-Appellants relative to the same.

	hrs.
06/10/80 Consideration and planning of appeal and cross-appeal strategy	1.3
06/17/80 Preparation of formal appellate papers for filing	2.8
07/22-24/80 Review of defendants' filings and reading and summarizing of trial transcript of 1,000 pages	8.4
08/16-23/80 Drafting, research and preparation of appellate brief in final form	27.6
10/01-03/80 Drafting, research and preparation of appellate reply brief	8.7
11/13-17/80 Preparation for and attendance at oral argument in Fayetteville, Arkansas	14.3
07/08-09/81 Review of appellate decision and planning of strategy for remand hearing	3.6
07/10/81 Conference with clients relative to explanation, significance and impact of appellate decision on delivery of services	5.2
07/14/81 Research on question of emancipation relative to challenged §188.028	2.9
07/09/81 Prepare subpoenas for remand witnesses	2.2
07/20-21/81 Prepare for and taking of deposition of Dr. Ward Cates in Atlanta, Georgia	9.8
07/23/81 Confer with clients re trial preparation	2.8
07/24/81 Telephone conference with Drs. Eubanks and Henshaw re trial testimony	2.3

07/30/81 Statistical research re trial preparation	2.7
07/30/81 Prepare trial subpoenas	1.8
07/31/81 Review statistics, speak with witnesses	2.1
08/04/81 Make travel arrangements, speak with opposing counsel, Judge Hunter's clerk and clients; prepare for trial	4.2
08/06-07/81 Trial on remand in Kansas City, Missouri and preparation for same	18.0
08/10-11/81 Preparation of post-hearing brief	6.1
08/17/81 Preparation of post-hearing brief	3.1
10/06/81 Review of Opinion on Remand and discussions with client	2.3
12/01/81 Review of appellate decision, discussions with clients and preparation of Rule 17 motion and affidavit for fees and costs	5.1

4. Affiant's total hours expended (excluding any participation of legal associate's time at appellate argument) were 137.3 hours.

5. Affiant's most recent award of fees by a federal court for abortion related litigation was received in *Wolfe* v. *Stumbo,* 519 F.Supp. 22 (W.D.Ky. 1980). In *Wolfe, supra,* Chief Judge Allen awarded to affiant $100.00 per hour for out-of-court time and $125.00 per hour for in-court time.

6. Affiant believes that $125.00 is a reasonable and customary fee for appellate work in this area based upon counsel's expertise, time devoted and other relevant factors.

7. Affiant requests on behalf of plaintiffs a reasonable award of attorney's fees of $17,162.50.

8. Costs incurred during the appellate process were:

(a) Reproduction of type-written appellate briefs	$149.98
(b) September 1980 long distance telephone	2.19
(c) Air fare for appellate argument, St. Louis/Springfield, Missouri	176.00
(d) Hotel, meals, rental car (Springfield, Missouri to Fayetteville, Arkansas), *etc.* re appellate argument	153.70
(e) April 1981 long distance telephone	2.19
(f) Service fee to U.S. Marshall	23.00
(g) Air fare for deposition of Dr. Cates, St. Louis/Atlanta	234.00
(h) Meals, airport parking, rental car, hotel, *etc.* re deposition of Dr. Cates	87.31
(i) Witness fee of Wayne Schramm	102.90
(j) June 1981 long distance telephone	1.73
(k) Service fee for Dr. Cates	4.40
(l) Deposition of Dr. Cates	314.60
(m) Sheriff's fee for Wayne Schramm	3.50
(n) Extraordinary mileage (St. Louis/Jefferson City, Missouri) and meals, hotel, *etc.* to interview Wayne Schramm	104.12
(o) Air fare of Dr. Eubanks, Louisville, Kentucky/Kansis City, Missouri	316.00
(p) Honorariums to Drs. Eubanks and Henshaw as witness fees, $250.00 each	500.00

(q) Hearing transcript of District Court remand proceedings	224.22
(r) Marshall's fee for subpoena service	5.60
(s) August 1981 long distance telephone	108.34
(t) Air fare New York City/Kansas City, hotel, meals, *etc.* for Dr. Henshaw	875.94
(u) September 1981 long distance telephone	22.15
(v) Extraordinary copying charges	70.31
(w) October 1981 long distance telephone	4.17

9. Said reasonable costs (excluding any costs pertaining to court attendance of named parties or their employees) were $3,551.93.

10. A review of plaintiffs' prevailing status by sections challenged reveals:

(a) §188.020 Plaintiffs prevailed on statutory construction grounds

(b) §188.025 Plaintiffs prevailed on constitutional grounds

(c) §188.028 Plaintiffs did not prevail

(d) §188.030.1 Plaintiffs did not prevail

(e) §188.030.2 Plaintiffs did not prevail

(f) §188.030.3 Plaintiffs prevailed on constitutional grounds

(g) §188.039 Plaintiffs prevailed on constitutional grounds

(h) §188.047 Plaintiffs prevailed on constitutional grounds

(i) §188.052.2 Plaintiffs prevailed on statutory construction grounds

11. Defendant's counsel has informed plaintiffs' counsel that they will vigorously oppose any claim by plaintiffs for reimbursement of fees or costs relative to the taking of Dr. Cates' deposition. Defendants desired that said deposition be taken by telephone and not in person and defendants filed motions with the District Court to that effect. Said motions were overruled and plaintiffs proceeded to take Dr. Cates' deposition in Atlanta, Georgia, the situs of his residence and his employment. Said deposition was necessary by reason of the policy of deponent's employer, the United States Department of Health and Human Services prohibiting the appearance of its employees at trial without formal subpoena. Plaintiffs chose not to introduce such deposition at trial by reason of it proving to be cumulative, a fact which could not be determined in advance of its taking. Dr. Cates is one of the foremost demographers and statisticians in the abortion field. Defendants chose to introduce such deposition into evidence and the same was relied upon by both the District Court and the Appellate Court in their respective decisions. The taking of such deposition was not frivolous, as the District Court determined, nor unnecessary and proved to be valuable to both reviewing Courts, as well as to defendants based upon their introduction of the same into evidence.

ACCORDINGLY, Appellees//Cross-Appellants pray for an order awarding to them their reasonable attorneys' fees of $17,162.50 and costs of $3,551.93 for a total award against Appellants/Cross-Appellees of $20,714.43 incurred in these appeals.

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IN THE UNITED STATES COURT OF APPEALS FOR THE EIGHTH CIRCUIT

Nos. 80-1130 & 80-1530

Planned Parenthood Association of Kansas City,
Missouri, Inc., *et al.*,
Appellees/Cross-Appellants,

v.

John Ashcroft, *et al.*,
Appellants/Cross-Appellees.

SUGGESTIONS OF APPELLANTS/CROSS-APPELLEES IN OPPOSITION TO MOTION FOR ATTORNEYS' FEES AND COSTS

(Filed January 19, 1982)

Come now the appellants/cross-appellees, pursuant to the provisions of Rule 17, Rules of the United States Court of Appeals for the Eighth Circuit and the request of Chief Deputy Clerk Linda L. Penberthy that a response be filed on or before January 18, 1982, and submit their suggestions in opposition to the motion of appellees/cross-appellants for attorneys' fees and costs allegedly incurred during appeal.

In the United States District Court for the Western District of Missouri, Central Division, this case involved a challenge by plaintiffs, appellees/cross-appellants in this Court, against the constitutionality of eight sections of the Missouri statutes relating to and regulating abortions. The District Court issued its declaratory judgment holding all or part of five separate sectionsof the Missouri statutes unconstitutional. *Planned Parenthood Association of Kansas City, Missouri, Inc.* v. *Ashcroft*, 483 F.Supp. 679 (W.D.Mo. 1980). Both plaintiffs and defendants appealed from the judgment of the District Court. The defendants appealed the District Court's holdings on the unconstitutionality of a provision requiring second trimester abortions to be performed in a hospital, parental or judicial consent requirements for minors, restrictions on abortions of viable fetuses, and informed consent requirements. The plaintiffs cross-appealed from the District Court's refusal to declare unconstitutional provisions requiring that informed consent information must be given by the attending physician, that tissue samples from all abortions must be submitted to a pathologist, and completion of individual reports on women seeking post-abortion care.

On their appeal, defendants lost on the second trimester hospitalization requirement, on that portion of the statutory restrictions on abortions of viable fetuses requiring the presence of a second physician, and on the informed consent requirements in Missouri law. The defendants won on appeal their challenge with respect to the District Court's ruling on parental or judicial consent requirements for minors and on the majority of the statutory provisions relating to restrictions on the abortion of viable fetuses.

On appeal, the plaintiffs were successful in challenging the District Court's ruling on the submission of tissue samples from all abortions to a pathologist. The plaintiffs were unsuccessful on the other points which they maintained on appeal.

Under the circumstances, the defendants respectfully submit that this is a case in which the Court should either exercise the jurisdiction inferred upon it by Title 42 U.S.C. §1988 to deny attorneys' fees on appeal to plaintiffs or find, appropriately upon the facts, that the plaintiffs did not prevail on appeal. The fact that plaintiffs do not believe they prevailed upon their appeal to this Court is made obvious by their recent filing of a petition for writ of certiorari with the United States Supreme Court. The defendants respectfully submit that they were substantially successful on their appeal from those sections of the findings of the

District Court with which they disagreed. The most important section of Missouri statutory law invalidated by the District Court related to parental or judicial consent requirements for minors. The defendants were successful in appealing that section of the lower court's order. The plaintiffs have already sought review in the United States Supreme Court from the defendants' successful appeal on that issue. Further, defendants were successful in overturning the majority of the District Court opinion relating to abortions of viable fetuses. Again, the defendants prevailed on appeal on this issue. On the other hand, plaintiffs were mostly unsuccessful on appeal. Of the three findings of the District Court appealed by the plaintiffs, they prevailed only with respect to the provision relating to the submission of tissue samples from all abortions to a pathologist. Respectfully, the defendants submit that they were more successful on the appeal and cross-appeal of the lower court's decision than were the plaintiffs, and, if either party is to be considered as prevailing on appeal, the defendants have prevailed. However, it is the plaintiffs who have demonstrated the fall to request attorneys' fees and costs on appeal. We submit that this is an appropriate case for each party to bear its own attorneys' fees and costs. Certainly, the plaintiffs are not indigents who need the incentive of an award of attorneys' fees on appeal to reward them for acting as private attorney general. Apart from the fact that they were largely unsuccessful on appeal, the plaintiffs have been in the forefront of abortion litigation in this state for a number of years and operate abortion clinics which are highly profitable enterprises. Given the relative success of the parties on appeal, the defendants submit that this Court should exercise its discretion to deny attorneys' fees and costs to the plaintiffs or, in the alternative, find affirmatively that plaintiffs did not prevail. Defendants also refer the Court to pages 4 and 5 of the plaintiffs' affidavit in support of their motion for attorneys' fees. As a caveat, defendants inform the Court that where plaintiffs purport to have prevailed on statutory construction grounds, that should be construed as plaintiffs' way of saying they lost. Further, the whole litany of success reported by plaintiffs should be disregarded in favor of the Court's own perusal of its opinions on appeal.

The defendants also submit that the requested hourly rate of $125.00 for Mr. Susman's services is unreasonable. Of the approximate 137.3 hours claimed by Mr. Susman on appeal, approximately 11 present in-court time. Furthermore, results obtained by Mr. Susman on appeal should be relevant to the excessive hourly rate requested. Admittedly, plaintiffs met with considerable success before the District Court. However, much of the District Court opinion in their favor was reversed on appeal. The only thing which plaintiffs, represented by Mr. Susman, gained on appeal is the invalidation of a requirement that tissue samples be studied by a pathologist, an insignificant victory indeed in light of the substantive issues presented to this Court.

It is difficult for defendants to attack the specific hours claimed by Mr. Susman on appeal in his affidavit because no supporting documentation has been provided to defendants. However, defendants submit that the 137.3 hours on appeal is not only excessive but ridiculous. The defendants submit that it would be a landmark result if this Court should award the $20,714.43 requested in attorney's fees and costs for only the appeal portion of this proceeding.

The defendants wish to make special reference to the attorneys' fees and costs pertaining to the deposition of Dr. Cates conducted in Atlanta, Georgia. The plaintiffs claim 9.8 attorney's hours and $640.31 in costs relating to that deposition. The deposition was absolutely unnecessary and represented an outrageous waste of time for all counsel. Counsel for the defendants asked Mr. Susman, and petitioned the District Court, that the deposition of Dr. Cates, if necessary, be conducted by written interrogatories or over the telephone pursuant to

Federal Rule. Defendants' attempts in that regard went unheeded. As a result, the attorney for the defendants was required to waste two days of his time and considerable state funds for expenses to attend a deposition which availed plaintiffs nothing. Not one word of the deposition of Dr. Cates was entered into the record by Mr. Susman during the remand of this case. In a private conversation with the undersigned, Mr. Susman admitted that Dr. Cates was a poor witness and that his deposition was essentially worthless. It would appear that Mr. Susman could have made that assessment by telephone without wasting his and defense counsel's time. It should now be obvious that the undersigned counsel was and remains extremely upset about the time and expense of Dr. Cates' worthless deposition. If anyone requests a check which includes reimbursement to Mr. Susman for the time and expense of taking that deposition, it will not be the undersigned attorney.

Mr. Susman requests his "reasonable attorneys' fees of $17,162.50." That request is an absolute contradiction in terms. Not only was Mr. Susman highly unsuccessful on appeal, but such an award of attorneys' fees during the appellate portion of a case would be unprecedented and incredible.

CONCLUSION

The appellants/cross-appellees, defendants in the District Court, respectfully submit that this Court should exercise its discretion under Title 42 U.S.C. §1988 to deny to plaintiffs attorneys' fees and costs on appeal in a case in which defendants were considerably more successful during the appeal process than were the plaintiffs. Further, the appellants/cross-appellees request that the Court find that plaintiffs did not prevail on appeal for purposes of attorneys' fees and costs. The appellants/cross-appellees ask the Court to find that the attorneys' fees and costs requested by appellees/cross-appellants are entirely unreasonable, especially with respect to the amount of hours and the hourly rate claimed for attorneys' fees. Finally, with respect to the attorneys' fees and expenses attributable to the entirely unnecessary deposition of Dr. Cates, defendants object specifically to their allowance. Defendants advise the Court that the affidavit of Mr. Susman does not provide sufficient information to attach hours specifically claimed, but that the hourly rate of $125.00 does not comport with general practice in the St. Louis area. However, those factors have not been discussed at length herein because defendants believe this is an appropriate case for the denial of fees and costs because they were more successful during the appeal process that were plaintiffs.

Respectfully submitted,

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/s/ MICHAEL L. BOICOURT
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Attorneys for Appellants/
Cross-Appellees.

UNITED STATES COURT OF APPEALS
FOR THE EIGHTH CIRCUIT

September Term, 1981

Nos. 80-1130 and 80-1530

Planned Parenthood Association of Kansas City, Missouri,
Inc., et al.,
Appellees-Cross/Appellants,

vs.

John Ashcroft, Attorney General of State of Missouri,
et al.,
Appellants-Cross/Appellees.

Appeals from the United States District Court
for the Western District of Missouri.

(Filed March 12, 1982)

The Court having considered appellees-cross/appellants' motion for attorneys' fees and costs and objections thereto of Appellants-cross/appellees, it is now here ordered by the Court that appellees-cross/appellants are awarded the sum of $7,500.00 for attorneys' fees and 75% of its costs on its briefs and the transcript on appeal.

Recovery costs are as follows:

Total costs of briefs:	$149.98
75 per cent recoverable costs of brief:	$112.49
Total costs of transcript:	$224.22
75 per cent recoverable costs of brief:	$168.17

Appellees-cross/appellants should collect all the Marshal fees and witness fees used on the remand. The parties are to divide the costs of the deposition transcript; otherwise each party is to pay their own costs.

March 12, 1982

Order entered at the Direction of the Court:

Robert D. St. Vrain
Clerk, U. S. Court of Appeals, 8th Circuit.

PLAINTIFFS' EXHIBIT 3

ANNUAL SUMMARY 1976
Issued August 1978

CENTER FOR DISEASE CONTROL
ABORTION SURVEILLANCE
1976

U.S. DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
PUBLIC HEALTH SERVICE
CENTER FOR DISEASE CONTROL

Plts
3

Table 16
REPORTED LEGAL ABORTIONS BY WEEKS OF GESTATION* AND STATE OF OCCURRENCE, SELECTED STATES,** 1976

State	≤ 8		9-10		11-12		13-15		16-20		≥ 21		Unknown		Total	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
Alaska[1]	378	31.2	525	43.3	245	20.2	16	1.3	18	1.5	0	0.0	31	2.6	1,213	100.0
Arizona	1,868	35.9	1,495	28.7	1,021	19.6	187	3.6	410	7.9	2	0.0	219	4.2	5,202	100.0
Arkansas	1,711	52.1	735	22.4	421	12.8	12	0.4	405	12.3	2	0.1	0	0.0	3,286	100.0
California	52,249	36.6	39,537	27.7	23,120	16.2	12,604	8.8	8,276	5.8	1,644	1.2	5,163	3.6	142,593	100.0
Colorado	2,805	24.3	2,899	25.1	1,787	15.5	971	8.4	848	7.3	278	2.4	1,951	16.9	11,539	100.0
Connecticut[1]	6,445	47.9	4,277	31.8	1,682	12.5	132	1.0	522	3.9	41	0.3	348	2.6	13,447	100.0
Dist. of Col.	19,624[2]	62.5	6,041[2]	19.2	2,439[2]	7.8	1,100	3.5	999[2]	3.2	17[2]	0.1	1,187	3.8	31,407	100.0
Georgia	11,457	44.8	9,075	35.5	3,740	14.6	236	0.9	848	3.3	120	0.5	110	0.4	25,586	100.0
Hawaii	1,817	35.2	1,578	30.6	875	16.9	432	8.4	297	5.8	88	1.7	76	1.5	5,163	100.0
Illinois	41,613	62.7	13,790	20.8	6,165	9.3	383	0.6	1,386	2.1	34	0.1	3,005	4.5	66,356	100.0
Indiana	5,176[3]	60.1	2,573[2]	29.9	750[2]	8.7	95[2]	1.1	16	0.2	2	0.0	0	0.0	8,610	100.0
Kansas	3,358	36.7	2,118	23.1	1,668	18.2	1,066	11.6	796	8.7	123	1.3	25	0.3	9,154	100.0
Kentucky[3]	2,446	28.4	3,010	34.9	3,160	36.7	0	0.0	0	0.0	0	0.0	0	0.0	8,616	100.0
Louisiana	4,257	67.0	1,213	19.1	773	12.2	45	0.7	16	0.3	5	0.1	41	0.6	6,350	100.0
Maryland	9,721	47.1	5,591[2]	27.1	3,047[2]	14.8	684[2]	3.3	1,409[2]	6.8	187	0.9	2	0.0	20,641	100.0
Massachusetts	17,201	52.4	9,307	28.4	3,599	11.0	798	2.4	1,707	5.2	177	0.5	12	0.0	32,801	100.0
Minnesota	4,733	33.5	4,710	33.3	2,331	16.5	1,039	7.4	1,289	9.1	22	0.2	0	0.0	14,124	100.0
Mississippi	583	38.6	538	35.6	238	15.8	40	2.6	22	1.5	2	0.1	87	5.8	1,510	100.0
Missouri	4,227	32.8	3,966	30.8	4,051	31.4	491	3.8	111	0.9	10	0.1	25	0.2	12,881	100.0
Montana	641	35.6	549	30.4	303	16.8	68	3.8	36	2.0	1	0.1	205	11.4	1,803	100.0
Nebraska	923	23.2	1,253	31.5	1,020	25.6	422	10.6	261	6.6	38	1.0	60	1.5	3,977	100.0
Nevada	1,717	72.1	323	13.6	183	7.7	37	1.6	78	3.3	3	0.1	41	1.7	2,382	100.0
New Hampshire[4]	728	37.2	734	37.5	424	21.7	18	0.9	2	0.1	0	0.0	52	2.7	1,958	100.0
New Jersey	7,282	57.0	2,876	22.5	1,370	10.7	77	0.6	931	7.3	127	1.0	120	0.9	12,783	100.0
New York	62,941	42.6	41,312	27.9	21,709	14.7	6,691	4.5	9,034	6.1	2,995	2.0	3,178	2.1	147,860	100.0
(City)	(44,790)[3]	(43.9)	(28,508)[2]	(27.9)	(15,536)[2]	(15.2)	(3,914)	(3.8)	(5,626)	(5.5)	(1,936)	(1.9)	(1,706)	(1.7)	(102,016)	(100.0)
(Upstate)	(18,151)	(39.6)	(12,804)	(27.9)	(6,173)	(13.5)	(2,777)	(6.1)	(3,408)	(7.4)	(1,059)	(2.3)	(1,472)	(3.2)	(45,844)	(100.0)
N. Carolina	8,219	34.9	7,342	31.2	3,716	15.8	1,521	6.5	1,393	5.9	219	0.9	1,151	4.9	23,561	100.0
Ohio	21,230	57.1	3,832	10.3	997	2.7	775	2.1	724[2]	1.9	288[2]	0.8	9,346	25.1	37,192	100.0
Oregon	5,335	42.4	4,109	32.6	1,955	15.5	336[2]	2.7	689[2]	5.5	68	0.5	98	0.8	12,590	100.0
Pennsylvania	23,675	45.3	16,477	31.5	6,362	12.2	1,739	3.3	2,849	5.5	228	0.4	931	1.8	52,261	100.0
Rhode Island	1,084	28.1	1,680	43.5	593	15.4	187	4.8	309	8.0	10	0.3	0	0.0	3,863	100.0
S. Carolina	1,927	33.8	1,690	29.6	1,016	17.8	272	4.8	145	2.5	32	0.6	620	10.9	5,702	100.0
S. Dakota[1]	523	33.5	312	20.0	260	16.7	165	10.6	182	11.7	110	7.0	9	0.6	1,561	100.0
Tennessee	5,936	35.0	5,397	31.8	3,265	19.2	897	5.3	299	1.8	92	0.5	1,081	6.4	16,967	100.0
Utah	1,053	41.4	787	31.0	456	17.9	95	3.7	112	4.4	1	0.0	38	1.5	2,542	100.0
Vermont	1,134	48.8	791	34.1	341	14.7	50	2.2	5	0.2	0	0.0	1	0.0	2,322	100.0
Virginia	10,388	45.9	6,831	30.2	3,089	13.6	470	2.1	1,545	6.8	127	0.6	185	0.8	22,635	100.0
Washington	13,720	60.2	5,405	23.7	2,009	8.8	475	2.1	975	4.3	136	0.6	70	0.3	22,790	100.0
Total	360,123	45.3	214,678	27.0	110,160	13.9	34,626	4.4	38,944	4.9	7,229	0.9	29,468	3.7	795,228	100.0

[1] Weeks of gestation based on physician's estimate

[2] Reallocation of reported abortions into comparable categories based on percentage distribution of abortions by single weeks of gestation reported from 24 states

[3] Based on distribution of data from hospitals and/or facilities reporting approximately 56% of total abortions

[4] Detailed data from late reports not available, but are distributed based on non-late reports

*Weeks from last menstrual period

**All states with data available (37)

PLAINTIFFS' EXHIBIT 1

ANNUAL SUMMARY 1977
Issued September 1979

CENTER FOR DISEASE CONTROL
ABORTION
SURVEILLANCE

Plaintiffs
Ex 1

U.S. DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE • Public Health Service

Table 18
REPORTED LEGAL ABORTIONS BY TYPE OF PROCEDURE AND WEEKS OF GESTATION,* 1977

Type of Procedure	Weeks of Gestation															
	≤ 8		9-10		11-12		13-15		16-20		≥ 21		Unknown		Total	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
Curettage	237,192	98.7	133,886	98.6	66,867	97.4	13,190	73.3	3,796	16.7	604	12.7	11,416	89.5	466,951	92.8
Intrauterine saline instillation	290	0.1	395	0.3	771	1.1	3,001	16.7	11,385	50.1	3,055	64.3	418	3.3	19,315	3.8
Intrauterine prostaglandin instillation	112	0.0	98	0.1	246	0.4	1,089	6.0	5,845	25.7	600	12.6	195	1.5	8,185	1.6
Hysterotomy	48	0.0	38	0.0	45	0.1	73	0.4	85	0.4	20	0.4	9	0.1	318	0.1
Hysterectomy	179	0.1	95	0.1	84	0.1	80	0.4	124	0.5	17	0.4	23	0.2	602	0.1
Other	700	0.3	355	0.3	230	0.3	454	2.5	1,287	5.7	429	9.0	33	0.3	3,488	0.7
Unknown	1,870	0.8	886	0.7	411	0.6	119	0.7	221	1.0	27	0.6	662	5.2	4,196	0.8
Total	240,391	100.0	135,753	100.0	68,654	100.0	18,006	100.0	22,743	100.0	4,752	100.0	12,756	100.0	503,055	100.0

*Based on data from 28 states

Table 23
DEATH-TO-CASE RATE* FOR LEGAL ABORTIONS
BY TYPE OF PROCEDURE AND WEEKS OF GESTATION
UNITED STATES, 1972-1977

Type of Procedure	Weeks of Gestation						
	≤ 8	9-10	11-12	13-15	16-20	≥ 21	Total
Curettage	0.5	1.6	2.9				1.2
Dilatation & evacuation				6.7	12.9	16.7	8.3
Instillation	0.0	0.0	0.0	9.6	15.4	24.7	14.1
Saline	0.0	0.0	0.0	2.5	19.3	20.6	15.5
Prostaglandin and other agents[1]	0.0	0.0	0.0	32.6	6.1	40.5	10.8
Hysterotomy/ Hysterectomy	0.0	58.8	39.7	70.8	47.8	157.5	45.3
Total[2]	0.5	1.7	3.0	9.9	16.3	27.9	2.6

[1] Denominators for rates include abortions reported as type of procedure "other" (1% of all abortions with procedure known)

[2] Includes deaths with type of procedure "other" (4) and unknown (2)

*Deaths per 100,000 abortions; based on distributions of abortions with type of procedure and weeks of gestation known

DEPOSITION OF DR. DANIEL J. MARTIN

(October 10, 1979)

(Defendants' Exhibit Q)

*[76] Q. You also indicated that it was not necessary at all for a second physician in the case of a method of D. & E. being used under these circumstances because a live [77] birth was basically an impossibility, correct? A. I would say it is an impossibility, yes.

Q. So there is no need, in your opinion, for a second physician in that case? A. True. ...

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* Numbers appearing in brackets in text indicate page numbers of original stenographic transcript of testimony.

DEPOSITION OF DR. WILLARD CATES, JR.

(July 21, 1981)

(Defendants' Exhibit 1, On Remand)

*[3] DIRECT EXAMINATION

By Mr. Susman:

Q. Would you state your name, please? A. Willard Cates, Jr.

Q. And where do you reside? A. In Atlanta, Georgia.

Q. And you are employed, are you not? A. Yes, I am, by the Centers for Disease Control, a federal preventive medicine agency.

Q. And that is part of the Department of Human Health Services of the federal government? A. That is correct.

Q. And what is your position? A. I am Chief of the Abortion Surveillance Branch of the Family Planning Evaluation Division at the Centers for Disease Control.

Q. How long have you held that position? [4] A. I've been Chief of the Branch for five years and have been in the Branch for a total of seven years.

Q. And in that position would you briefly describe your duties? A. We monitor the number and characteristics of women obtaining abortions in the country and initiate studies in order to reduce preventable morbidity and mortality from the procedure.

Q. Would you state your educational background and qualifications? A. I received my undergraduate degree in 1964 from Yale University. I received a Master's Degree in history from Cambridge University in 1966 and returned to Yale University School of Medicine where I received a combined M.D. and M.P.H. Degree in 1971. I then completed a year of internal medicine internship at the University of Virginia in Charlottesville and then went into the army for two years as a preventive medicine officer before coming to the Centers for Disease Control.

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* Numbers appearing in brackets in text indicate page numbers of original stenographic transcript of testimony.

* * * * * * *

[6] Q. Have you published in the area of abortion statistics, abortion surveillance? A. Yes, I have.

Q. Approximately how many articles? A. Approximately 120 articles in the field of abortion and abortion complications.

* * * * * * *

Q. Doctor, are you familiar with the various methods by which second-trimester abortions are performed in the United States? A. Yes, I am.

Q. Would you briefly just tell us what those methods are? A. In short, there are three predominant methods of terminating pregnancies later than 12 weeks' gestation, and, when I use the term "second-trimester," I'm referring to those pregnancies of [7] 13 menstrual weeks' gestation or later.

The first method used is the intraamniotic instillation of hypertonic saline, which involves an amniocentesis procedure, infecton of hypertonic saline into the amniotic cavity that eventually leads to labor and expulsion of the fetus and placenta.

Q. Doctor, if you would just briefly tell us the methods since we've already had testimony in this case as to the procedures. A. The second is intrauterine instillation of prostaglandin F2 alpha.

And then the third, which has been practiced with increasing frequency in the country. is a method called dilatation and evacuation.

Q. Are you able to tell us the related prevalence of these methods in 1973 in the United States? A. Yes, in approximate terms. Saline accounted for approximately 80 percent of all second-trimester procedures. Prostaglandin was not licensed in 1973, so that does not account for very many at all. And D&E, an estimated 20 percent.

Q. And are you able to tell us the prevalence today? A. Yes. In the most recent year for which we have information, 1978, D&E accounted for 51 percent **[8]** of all second-trimester procedures; saline for approximately 30 percent and prostaglandin for approximately 20 percent.

* * * * * * *

[9] Q. The three methods of second-trimester procedures that you discussed, would you tell us whether they are routinely done inhospital or outhospital or both? A. In general nearly all instillation procedures, whether of saline or prostaglandin, are done as hospital procedures, and they certainly are finished as hospital procedures even though if sometimes the initial instillation is begun outside the hospital. Once labor has begun, most physicians **[10]** recommend that women return to the hospital immediately for delivery.

As far as D&E procedures go, approximately — my rough estimate is that probably about two-thirds of those procedures are performed in nonhospital settings.

* * * * * * *

[11] A. We found that the crude death-to-case rate **[12]** was in fact higher for D&E procedures performed in hospitals than those performed in nonhospital facilities. However, in terms of the inferences we draw from the crude rate, we're cautious for several reasons. First of all, the numbers were quite small, and proved statistical differentiation does not exist between the rates of dying from D&E's performed in nonhospitals or hospitals.

Secondly, it's possible that women were hospitalized to have their D&E performed because they were at higher risk to begin with, and this would create a spuriously higher death-to-case rate for those procedures performed in hospitals. However, we do interpret the data cautiously and say that D&E's performed in nonhospital settings appear to have no greater risk than those performed in hospitals.

Q. Have you received any data since 1978 which would alter that conclusion? A. No, we have not.

Q. And can you relate for us any differences in morbidity? A. We have one ongoing study of abortion complications that I described earlier, and we have one institution in that particular study that has changed its abortion practices from performing predominantly saline instillation procedures to [13] prostaglandin instillation procedures and finally to D&E procedures, initially performed in a hospital setting and then later performed in its own clinic. And our preliminary and provisional analysis of data from that institution underscores the findings that we have had from our analysis of deaths, namely for this group. It was no safer to have their D&E procedures performed in the hospital than it was to be performed at the clinic.

Q. Is that a significantly large enough sample? A. Yes. Now, that particular sample and this particular group was large enough that these complications — it's unlikely that chance could have accounted for the absence of difference in D&E's performed in either hospitals or nonhospitals.

* * * * * * *

[15] Q. Have you done any studies as to whether or not a statutory requirement of inhospital for second-trimester and later procedures, as to how that affects the availability of abortions and the numbers performed during the second trimester and later? A. We have not done any study to that effect. However, I am aware of studies performed by the Alan Guttmacher Institute, a research and development —

Mr. Boicourt: Objection. Hearsay. Go ahead.

A. (Continuing) — a research and development wing of Planned Parenthood, who have analyzed the effect of regulations requiring abortions being performed in hospitals, and they have found that in selected areas, those states where it has been looked at, it has had the effect of limiting the availability of second-trimester procedures.

* * * * * * *

[18] Q. As a physician, do you have any reason to believe that the performance of D&E procedures during second trimester within the confines of a hospital would be safer than the performance of those same procedures on an outpatient basis?

Mr. Boicourt: I object to that question on the lack of foundation.

By Mr. Susman:

Q. You may answer. A. As a physician, we are customarily taught that the hospital is the place that has backup facilities necessary to treat emergencies, and therefore intuitively people might believe that the hospital would be the safest place in order to conduct surgical procedures. However, the data with regard to abortions and other ambulatory low-risk surgical procedures have indicated that they can be safely performed outside the hospital and in some cases, because there has been a development of individuals with particular skills in either ambulatory, gynecological procedures or other outpatient surgical procedures, can be done more safely than in some hospitals which involve either more individuals as part of the patient care or are involved **[19]** with training programs, and by that I mean individuals with less experience in particular procedures.

* * * * * * *

[21] Q. Are you able to tell us the maternal **[22]** mortality rate for child-bearing in the United States? A. Yes. The risk of the continuing of pregnancy to term, excluding those deaths that occur from either pregnancy or abortion — in other words, those that would occur early in the first trimester of pregnancy — it is approximately 10 per 100,000 procedures.

* * * * * * *

[25] Q. Let me show you what has been marked as Plaintiffs' Exhibit 3 for the purposes of this deposition. Can you identify that for us, please? A. Yes. This is a manuscript entitled "Legal Abortion and Women's Health: Gains and Losses in the 1970s."

Q. Can you briefly give us the conclusions of this study as to the effects upon legalization of abortion?

Mr. Boicourt: Again, my objection goes to this entire line of questions.

A. Very briefly, I document the effects that **[26]** the increasing availability of abortion has had on reducing deaths and complications in women of reproductive age and of improving the safety of abortion methods and increasing the sophistication of delivery of health care through the ambulatory facilities.

Q. Was there a direct effect upon maternal mortality? A. There was a direct effect upon abortion-related deaths. Yes, that is correct.

Q. And what were those figures, Doctor? A. In 1972, the first year we began collecting information on abortion-related deaths, there were 39 women who died after illegally-induced abortions. This number decreased over the next five years, reaching a nadir of 2 in 1976. Again there was this temporal association the increasing number of legal abortions that were performed, the increasing availability throughout the country.

Q. Was there an effect upon maternal mortality unrelated to abortions because of its availability? A. That's very hard to say. Maternal mortality during this time declined as well, though not at as rapid a pace as abortion-related mortality. If you wish to look at mortality from other causes of death related to pregnancy and contrast that with abortion **[27]** in the early 1970's, certainly up through 1976 abortion-related deaths declined more rapidly than deaths from other pregnancy-related causes. And it's our conclusion that this was primarily because the increasing availability of legal abortion was substituted for those pregnancies that would have been terminated through illegal channels that are less safe and have higher risks of morbidity and mortality.

Q. Doctor, you are married, are you not? A. Yes, I am.

Q. If your wife were to have a second-trimester abortion, what would be your method of choice?

Mr. Boicourt: Objection. Irrelevant.

A. My method of choice would be a D&E procedure and having it performed in a nonhospital facility by an individual who I knew was competent.

Q. Could you briefly tell us why your selection of location for the procedure would be an outpatient facility as opposed to a hospital? A. My personal observation has been that the care — the concern with the individual, as well as the convenience of the procedure and the cost of the procedure—is much less when delivered in a hospital facility. That's my particular personal observation, and that's why I would personally choose to have it **[28]** performed in one of the better facilities of which I'm aware.

Q. Would you have any concern about the safety of doing it outpatient as opposed to in a hospital for your own wife? A. I would have no concern at all about the safety in an outpatient setting given the practitioner and the facility that I would choose.

Cross Examination

By Mr. Boicourt:

[29] Q. The very first question I have for you, Dr. Cates, is that you personally consider yourself pro-choice? A. Yes. I personally support the position that the government should not involve itself in the very [30] difficult choice of a pregnant woman about whether to terminate or to continue her unplanned pregnancy. I do not feel that that personal position influences the way in which I interpret or disseminate the data that we collect.

Q. But you will admit to a personal position that is on one side of the issue at this point in time? A. Yes.

Q. I know it's a more complicated issue than just having two sides, but you do take a stand in the matter personally; is that correct? A. As an individual I have pro-choice feelings, specifically with regard to the role that the government takes with regard to the decision making of a pregnant woman.

Q. And I heard you make the statement earlier when we were off the record — and I'm not trying to cross you up, but you have been a target of what we call the "pro-lifers" from time to time? A. That's correct. I've also been the target of radical feminist groups from time to time as well.

* * * * * * *

[32] Q. Have you ever taken either an internship or a residency in OB/GYN? A. No, I've not.

Q. Have you ever performed an abortion? A. Yes, I have.

Q. How many? A. Approximately 30.

Q. And of those 30 abortions, how many have been performed in the second trimester? That is, 13 weeks and thereafter gestational age? A. I would estimate approximately 3 to 5 of those were at 13 weeks or beyond.

Q. And were those 3 to 5 procedures at 13 weeks and beyond performed in hospitals? A. Yes, they were.

Q. And what procedure did you use? A. I used what is commonly referred to as the D&E method, namely the evacuation of the uterine contents through a transvaginal approach.

Q. Now, with those procedures — I think you said approximately 3 to 5 — would they have been [33] performed between the 13th and 15th week of gestational age? A. Largely, yes, they would have been done during that time.

Q. Did you perform any abortions which would have been performed, to your best estimate, at 16 weeks or thereafter of gestational age? A. As I recall, I have done one that was estimated postoperatively to be at 16 weeks' gestation. That is the latest gestational age that I have personally performed a D&E.

Q. Dr. Cates, have you ever testified in any cases, before this case, in which regulations or statutes enacted by a state have been challenged in court? A. Yes, I have.

Q. Would you please summarize those instances? A. I have testified in two Tennessee cases involving challenges to state laws involving both hospital procedures as well as waiting periods and finally teenage consent provisions.

Q. Are those the only two cases in which you have testified regarding regulations or statutes enacted by states respecting the abortion process? A. The only two that I can remember.

[34] Q. And did you testify for the plaintiffs or for the State of Tennessee? A. I was the plaintiff's witness.

* * * * * * *

[36] Q. Now, with respect to the surveillance of abortions performed in the United States by your branch of the National

Centers for Disease Control, do all states presently report to you, all 50 states and the District of Columbia? [37] A. No. At present we have approximately 45 states that report directly to us, and then we canvas hospitals and facilities in approximately five to seven other reporting areas in order to come up with our totals.

Q. When you say you canvas facilities, do you mean clinics known by the Centers for Disease Control as performing abortions as part of their function? A. Yes. That is correct.

Q. And do you make any attempt to notify doctors individually whether or not they are performing abortions? A. We classify a doctor who performs more than 400 abortions a year as a facility.

Q. Would any doctor who performed less than 400 abortions a year not be classified as a facility and therefore not be surveyed? A. That's entirely possible.

* * * * * * *

[38] Q. Now, Dr. Cates, I understood you to testify that, as of the latest year for which complete figures have been tabulated by your branch — that is, 1978 — that dilatation and evacuation procedures constituted 51 percent of second-trimester abortions in the United States. Is that correct? A. That's correct.

Q. Do you think that all abortions performed in the United States are included in your statistics? A. No, I do not think that all abortions are included in our statistics. If we were to compare our data with those obtained by the Alan Guttmacher Institute, it appears that CDC may under-report the total number of abortions by some 15 to 20 percent.

[39] Q. Do you think it likely that the abortions which you under-report are those abortions which are less likely to have been performed either in hospitals or in abortion facilities which perform a number of abortions each year? A. My guess is that if

there is under-reporting, it would largely be nonhospital facilities, but we don't have good checks on what that is. It is really speculation.

Q. I also understood you to testify that there has been a percentage decline in second-trimester abortions from 1973 through 1978? A. That is correct.

Q. How much percentage decline? A. As I recall, the percent of abortions that were done in the second trimester was approximately 15 or 16 percent in 1972, and it was 9 percent in 1978. So there was a 7 point absolute percentage decline and about a 50 percent decline overall.

Q. Do you consider that a significant statistical movement? A. Yes, I do.

Q. Do you have any opinions as to the cause of that statistical change? A. My feeling is that the increased availability **[40]** of legal abortions allowed women to obtain procedures earlier in gestation as abortions became more widely available throughout the country. They didn't have to travel as far, and they could obtain the procedures earlier in gestation. Also, the advertising of abortion facilities, in my opinion, has had a positive effect on allowing women to make their decisions — in this case, to determine pregnancies — earlier in gestation.

Q. Is it not also possible, Doctor, that publicity on the fact that the longer a pregnant woman waits before she has an abortion, the more dangerous it is to her health may have had an effect on the decrease in second-trimester abortions? A. Yes. I would hope that the awareness by both providers and consumers alike that any delay increases the risk to the procedure would be one that would encourage early decision-making, either to terminate or to continue a pregnancy by the woman, so that she can seek the earliest possible care in her pregnancy.

Q. Dr. Cates, as I understood your testimony, approximately 49 percent of the second-trimester abortions performed in 1978 were done either by — in order to keep my use of technical terms as short as [41] possible — either by the instillation of saline or the instillation of prostaglandin; is that correct? A. In general that's correct. I did not talk about other methods such as urea or other combination abortifacients that are also being used. But in general, 49 percent are being done by instillation methods, yes.

Q. When you say "instillation methods," you mean both saline, prostaglandin or a combination of the two? A. Or other agents. For example, hypersmolar urea, which is another agent like saline. But it's the intraamniotic instillation of abortifacients, predominantly saline and prostaglandin and then possibly urea as well.

Q. With respect to — and we will use "trimesters" as we understand them, usually in medical terms now, the first 12 weeks being the first trimester and the second trimester starting at the 13th week of gestation — with respect to second-trimester abortions, do you suggest that any of those performed by the method of instillation should be performed outside of hospital settings? A. No, I do not suggest that, although there are some data to show that initiation of the [42] instillation procedure in a nonhospital setting with the eventual completion of the delivery of the fetus and products of conception within a hospital is very safe and also saves money.

Q. You certainly would not recommend, would you, that any instillation of either saline or prostaglandin in the second trimester would not include a period of hospitalization by the patient? A. You're correct.

Q. And again, approximately somewhat less but approximately one-half of all abortions performed in 1978 in the second trimester were performed by instillation techniques? A. That's correct.

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[43] Q. The National Centers for Disease Control does not, as I understand it, compile data on the number of D&E procedures performed in and out of hospitals? A. That is correct.

Q. Did I also understand you to say that — and I got a little bit confused at this point in time, so you might have to correct me — but there have been no controled studies to date of the comparative safety records of D&E procedures performed in and out of hospitals? A. That is correct.

[44] Q. How many deaths have resulted from D&E abortions since 1972, Dr. Cates? A. Eighteen women have died after D&E procedures in the United States since 1972 through 1978.

Q. Would it be fair to say, then, that your testimony concerning the mortality of D&E procedures in your article which is Plaintiffs' Exhibit 2 concerning mortality from D&E procedures were based on a statistical sample of 18 deaths? A. Eighteen deaths in the numerator. That is correct.

Q. Of those 18 deaths, how many resulted from second-trimester abortions performed outside of hospitals? A. As I recall, it was 11.

Q. And there were 7 in hospitals; is that correct? A. Yes. Yes, there were 11 deaths that occurred after procedures performed in nonhospital facilities; 7 after procedures performed in hospitals.

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[45] Q. Now, Doctor, it might be necessary for you to resort to Plaintiffs' Exhibit 4 somewhat, which is the 1978 surveillance report. In Plaintiffs' Exhibit 2, on the first page of the cover page, you state, consistent with your testimony this morning, that in 1978 D&E's became a leading method of abortion in the second trimester. I would like to have that broken down further, Dr. Cates. I would like for you to break down the percentage of procedures in the second trimester, percentage of abortions performed by procedure in the second trimester, first in 13 to 15 weeks, and secondly from 16 to 20 weeks, and then from 21 weeks and thereafter. I believe those are the figures which you have used previously, on the breakdown that you used previously. A. Right. In 1978 three-quarters of the D&E procedures were performed in the 13- to 15-week interval; 20 percent in the 15- to 20-week interval, and 3 percent at 21 weeks' gestation or later.

[46] Q. Now, for abortions performed in the 16th week or thereafter in 1978, were D&E's the leading procedure for those abortions? A. No, they were not.

Q. And certainly D&E was not the leading procedure used for abortions performed at 21 weeks and thereafter, were they? A. No, they were not.

Q. So is it fair to say that, with respect to second-trimester abortions, that D&E is the leading method or procedure only for those abortions performed between 13 and 15 weeks? A. That is correct.

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[47] Q. You state that the predominant causes of death resulting from abortions performed in the second trimester by the D&E procedure are infection and hemorrhage. Is that correct? **[48]** A. That is correct.

Q. Doctor, with respect to hemorrhage, are not hospitals better equipped with respect to blood available, blood banks, blood typing and every other thing I can think of to treat hemorrhage than are freestanding clinics who perform only abortions? A. Yes, hospitals are generally better equipped to treat the complications of hemorrhage than are clinics. However, with modern volume replacement capacity plus the capacity for intravenous administration of fluids, the nonhospital facilities can stabilize a patient who is hemorrhaging and get her to a hospital who will be able to treat those complications if the clinician has a low enough threshold for action, and the key determinant here is the threshold of the clinician to act urgently in situations that demand it.

Q. You have no way of knowing, do you, from your statistics the availability, by time and distance, of the clinics in the United States who perform abortions to hospitals which do have complete facilities for treating hemorrhages? A. No, we do not collect data in that regard.

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[52] Q. In the beginning of your report, Doctor, you give the other predominant cause of death — that is, other than hemorrhage that we have discussed — as infection. Is it not true that hospitals are better equipped to treat and deal with the sequelae of infection of all types than are freestanding abortion clinics created solely for the purpose of performing abortions? A. It depends actually on the particular hospital in this regard. Because hospitals are usually referral facilities for more serious complications, they have within their walls more resistance, more serious organisms. But, in general, if anybody has an emergent condition relating to infection, yes, a hospital would be the appropriate place to treat that complication. But the complication of an infection takes days and sometimes weeks to develop after an abortion procedure and would really be relatively unrelated to the facility in which it was performed, unlike a hemorrhage, which tends to be more emergent at the time of the procedure.

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[53] A. To strictly answer your question, I would assume that the woman would return to the facility where the procedure was performed. The next question is would she be treated by individuals in that facility who are familiar with the particular condition? And in my experience in hospitals, especially the large public hospitals that often times have fragmentary care, I

found that the individual performing the abortion might not be the individual who will be seeing her on an emergent basis were she to walk into the emergency room, for example.

[54] Q. Isn't that also true of abortion clinics, Doctor? A. Usually not. Again my understanding of it is that they usually have 24-hour backup by individuals, if not the specific individual performing the procedure, at least another individual who is very familiar with abortion complications. In the hospital's case, you might have an internist staffing the emergency room who is completely unfamiliar with what might be thought of as routine postabortion complications versus serious abortion complications. Perhaps more generic to the whole issue of infection is what is the risk of a particular individual to get an infection, depending upon what facility she had her abortion performed in. And we have found that probably the most important factor relating to infection is whether or not all products of conception were removed from her uterus at the time of the procedure, and therefore it might be — I feel, in fact, that an individual who took rather explicit care to insure the complete removal of all products of conception, that particular clinician would have a low risk of infection regardless of what facility the procedure was performed in.

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[55] Q. Would you also agree with me that you are less likely to find an OB/GYN with the best reputation and with the most influence and with the most patients working in an abortion clinic than you are on the staff of a hospital in any metropolitan area? A. I would guess that that might be the case.

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[56] Q. Dr. Cates, are abortions performed by the D&E procedure more dangerous to the health of the mother at 13 weeks or thereafter than they are at 12 weeks and before? A. Yes, they are.

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[60] Q. You do not recommend, do you, Doctor, that all providers should be providing abortions beyond 15 weeks by the D&E technique in other than hospital settings? A. No, I'm not recommending that all providers should be doing that.

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[67] Assume a facility which, on the record presently before us, has never performed an abortion beyond the first trimester. Given that posulation, should the facility be immediately allowed to being performing D&E procedures after 15 weeks?

Mr. Susman: I object to the question as having absolutely no relevance to the statute under consideration.

A. My particular preference would be that a track record of terminating pregnancies in the 13- to 16-week interval be shown, be created, before further advancing the gestational age. Now, again the situations are dependent upon the background of the [68] individuals performing the procedures as well as the professed willingness of the facility and track record of that particular facility to provide abortion procedures safely. But in an absolutely new case where a facility had never provided any abortions knowingly over 12 weeks, I would prefer to see the gestational age threshold for that particular facility being advanced in graduated stages.

Q. Before these suggestions or recommendations concerning the number of gestational weeks at which hospitalization may or may not be required on the basis of the evidence available to you, am I again correct in assuming that those recommendations were again based upon a statistical data base of only 18 deaths resulting from D&E procedures since 1972? A. Yes. There were 18 deaths. Now, you can look upon those 18 deaths as being prima facie evidence that the procedure is relatively safe compared to other procedures. But nonetheless it was a small number of cases that does allow statistical variation in the rate.

Q. Apart from statistical frequency, I think we can agree that 18 deaths is not something which we should not consider at all; it is not insignificant, is it? **[69]** A. No. Each of those deaths is a death that ought to be investigated or was investigated completely and analyzed as far as how it could have been prevented.

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[71] Q. Doctor, is it fair to say that some authorities feel that widespread use of D&E by physicians inexperienced in this technique may increase the risk of the procedure? A. Yes, that is fair to say.

Q. Is it also fair to say that some authorities feel that second-trimester D&E is so risky that it should be performed only in hospitals? A. That is correct also.

Q. Is it also fair to say that some authorities predict that the increasing use of D&E in nonhospital facilities will cause an increase in deaths and complications? A. Yes, that is also correct to say.

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[73] Q. Now, Dr. Cates, statistics compiled by the Centers for Disease Control do not include numbers of abortions by type of abortion facility, do they? A. No, they do not.

Q. So to that extent you relied upon compilations of statistics by others? A. That is correct.

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[75] Q. Okay, Doctor, I want to go back to what was originally going to be my question. It's not always easy for the treating physician to determine the gestational age, it is? A. It's certainly not always easy. In fact there is relatively frequent misestimation of gestational age at almost any gestation.

Q. And I think we agreed earlier that with each week of gestational age, the risk to the health of the mother increases considerably? A. That's correct.

Q. How much do they increase with each week? A. The risks of complications increase approximately 20 to 30 percent with each week, and the risk of dying approximately 40 to 50 percent with each week.

Q. And, as I understand your study of the 18 deaths which were available to you, in eight of those 18 cases the gestational age was underestimated by at **[76]** least four weeks? A. Correct.

Q. Now, we are talking about four week, and you said about 40 or 45 percent a week; if the gestational age is underestimated by at least four weeks, how much greater was the risk to the life of the mother statistically than the treating physician thought it was? A. Probably twofold greater. Again that's twofold of a relatively rare event, but nonetheless it's twofold greater.

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[78] Q. And I refer you to the bottom on Page 3. You say, "In 5 of the deaths" — that is the last sentence on Page 3. When you say, "In 5 of the deaths," do you mean 5 of the total 18 or 5 of the 11 which were performed in nonhospital clinics? A. I would have to check those exact cases, but I mean in 5 of the 18 a delay of more than 24 hours occurred between her initial symptoms and her eventual referral by the physician to a hospital. But I believe that all 5 of those occurred after nonhospital facility abortions.

Q. And with respect to those 5, I believe you state, ". . . a delay of more than 24 hours occurred between the onset of the woman's initial postabortion symptoms and her eventual referral by the physician to a hospital"? A. Correct.

[79] Q. Now, Doctor, I understand your statistics — referring you to Page 5 — as indicating that for D&E's performed at 16 weeks or later, the death-to-case rate was 14 per 100,000; is that correct? A. Yes, that is correct.

Q. That is a larger death-to-case rate than childbirth, is it not? A. Than that reported for pregnancy and childbirth. Now, mind you, there have been several recent studies just published showing that the number of deaths related to pregnancy and childbirth is probably under-reported by some 40 to 50 percent. So, if you were to add that 40 to 50 percent, it would be about equivalent to the risks of dying from D&E.

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[80] A. I take the position that certainly, through 16 weeks, that D&E abortions outside of hospitals are no more dangerous than D&E abortions performed in hospitals and in many cases are cheaper and more convenient.

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[81] Q. Would you recommend that your wife, if she were 21 weeks pregnant, have a D&E procedure performed upon her in a clinic? A. No, I would not recommend that.

Q. Isn't it also true, Doctor, that after 15 weeks the death-to-case rate for D&E, as compared to instillation agents of saline and prostaglandin, is quite similar? A. Yes.

Q. So again, when you were talking earlier on direct examination about the comparative safety of D&E, you were talking about D&E's performed at 13 to 15 weeks? A. All of the aggregate comparative advantage of D&E compared to instillation procedures based on national mortality data come from their comparative advantage in the 13- to 15-week interval. After 16 weeks mortality data don't allow differentiation among the different methods.

Q. Doctor, I want to refer you to Page 7 of your report, the middle complete paragraph. It's the [82] last sentence, and I want to read that sentence to you: "Although accurate determination of length of gestation might reduce complications and deaths from D&E, routine use of sonography increases both the cost and inconvenience of the procedure." Is that one of the statements you and your collaborator made in that article? A. Yes, it is.

Q. Do you believe that's true? A. I believe with the caveat "might" in there, it is true. If misestimation, which we have determined was operative in some of the cases, contributed to the risk of death, accurately determining gestational age, we feel, would reduce complications and deaths.

Q. It is true, is it not, that the routine use of sonography would improve the ability of the clinician to estimate the length of gestation? A. It probably would improve the ability of the clinician.

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[83] Q. Are there cases in which you would expect ultrasound to be available in every hospital? A. I don't know the answer to that. I would think that most hospitals would have ultrasound but that they do not always have facilities for immediate [84] availability of ultrasound to the individual, say, requesting pregnancy termination.

Q. Do you have an opinion as to whether every abortion clinic has available to it ultrasound? A. I would speculate that relatively few abortion clinics have an ultrasound as part of the regular equipment.

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[86] Q. And did you also conclude that many of these factors would "spuriously" raise the death-to-case rate for D&E's performed in hospitals compared to those performed in nonhospital facilities? A. Yes. It's our belief that the factors enumerated above — specifically the last one — would tend to spuriously raise on a comparative basis the risk of dying in hospitals compared to nonhospitals. And therefore that's why we say that we cannot find that abortions performed in hospitals are any more dangerous than those performed in clinics. But we don't want to imply that they are even though the crude data seem to imply that.

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[87] Q. Now, Dr. Cates, did you make any finding with respect to four of these deaths, women who died from internal hemorrhaging in nonhospital facilities, about whether the availability of blood bank services might have assisted in preventing their deaths? A. Yes. That certainly was a consideration of **[88]** ours.

Q. And did you not in effect find that the four women who did die from internal hemorrhage after uterine perforation in a nonhospital facility might have benefitted from immediate availability of blood bank services? A. That's certainly possible. And are you going to read on further in that paragraph that points out that three of the seven deaths from hemmorrhage after D&E occurrred in hospitals that had blood banks there? And what we've called for in the paper is physician recognition of the emergent nature of a particular problem rather than any inherent protection involved by it being in a facility. If anything, it's the threshold of recognition of the physician that's important rather than the availability of products.

Q. Well, certainly abortion clinics do not have blood banks? A. That is correct.

Q. Doctor, is it your opinion that all physicians are adequately trained by experience and education and the reading of articles concerning the latest techniques so safely perform D&E's in nonhospital facilities? **[89]** A. No, that is not my opinion.

Q. Now, Doctor, I believe one of the statements — and I'll start at the bottom of Page 10 of Exhibit 2, and it's the third from the last sentence there: "For D&E, this would prevent moving the threshold for required hospitalization from 12 to 16 weeks. As abortion techniques and physicians' skills improve further, the threshold could be slowly advanced. Proposed changes should be based on scientific evidence gathered through ongoing surveillance, however, rather than on unsubstantiated opinions." Is that a conclusion which your publication reached? A. Yes, it is.

Q. Now, I hate to be that repetitive, Doctor, but again we're talking about recommendations that you have made, together with your collaborator, based on a statistical data base of 18 deaths? A. That is correct. And, as scientists, we go where the available data are, and you have to proceed from the best available data at any point in time and make prudent recommendations based on those. And, quite clearly, the available data as it stands today cannot support a 12-week threshold on requiring that all procedures be performed in hospital facilities.

Q. You agree with me, do you not, that the **[90]** available data is severely limited? A. Limited. I might not use the word "severely."

Q. Doctor, during your direct examination — and I'm afraid I got a little bit confused — you talked about one study concerning morbidity as opposed to second-trimester abortions performed in and outside of hospitals. Do you recall your testimony in that regard? A. Yes, I do.

Q. Did I understand you to testify that that study was based upon only one facility's experience? A. Yes, it was.

Q. What facility is that, Doctor? A. The facility was Meadowbrook Women's Clinic in Minneapolis, Minnesota.

Q. And then you replied to Mr. Susman that you thought that this was a large enough sample for statistical validity. You were talking about one facility only and the experience of that one facility on morbidity in the second trimester for D&E's; is that correct? A. Yes. It's important that it be one facility —

Q. You've answered the question, Doctor. **[91]** A. — for scientific accuracy.

Mr. Susman: The witness can be allowed to finish his answer. Feel free to go ahead.

Mr. Boicourt: I didn't ask him why. Unless I ask him why, he's not entitled, he's not entitled to do that. I disagree with you most wholeheartedly.

Mr. Susman: You may finish your answer. The Court will strike it if they don't want to hear it. Go Ahead.

A. (Continuing) Scientifically, it is important that it be one facility because in that way, in a controlled manner, you will not have different clinicians performing procedures, and you will have the same facility and the same clinicians performing them both in hospitals through, first of all, instillation techniques and D&E's in hospitals and finally D&E's outside hospitals. So it comes closest to an experimental setting that is more valid scientifically.

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[93] Q. Now, Doctor, do you recall Mr. Susman asking you if you had an opinion on whether or not the second-trimester hospitalization requirement of various states had an effect on the availability of abortions? A. Yes.

Q. And do you recall stating that your opinion was based in part on the AGI statistics? A. Yes.

Q. There have been no other studies concerning [94] the effect on the hospitalization requirements on the availability of abortions, have there? A. Not to my knowledge.

Q. And you did not participate in the preparation of the Guttmacher study's statistics, did you? A. No, I did not.

Q. Isn't it also fair to say that the AGI statistics and conclusions, as you have been from time to time, have been attacked by pro-lifers? A. yes, they have.

Q. One thing we asked was about blood bank systems and their availability in hospitals and also that it was more likely that hospitals would have facilities for people experienced in using facilities and procedures for blood typing than abortion clinics? A. That's correct.

Q. And is it true that abortions performed by D&E procedures often can result in complications where blood typing would be important in treating the patient? A. That is correct. Let me also just amend my previous statement in that my understanding of most clinics is that they do routinely type every woman who comes in because of the risk of the Rh incompatibility, and a woman with an Rh negative blood type [95] would be administered Rhogam, so I would believe that most nonhospital facilities would have the capability for at least typing of the Rh factor.

Q. But not a complete blood typing? A. I'm not familiar with what most facilities do, but they do have some blood-typing capacity.

Q. And, given the example of a D&E procedure, say, at 15 weeks which resulted in perforation of the uterus, is it likely in that case that blood would be used to treat the patient? A. Perhaps at some point, depending upon the emergency basis of the hemmorrhage and whether or not the patient was in clinical shock and other factors.

Q. And hospitals would normally have better facilities for typing and better blood banks for treating that hemorrhage in that situation? A. Certainly they would have the blood as a backup. Again, I reserve judgment. I have no data to know what the differential capability of blood typing really is.

Q. Now, with respect to D&E procedures performed in the second trimester, certain medications are necessary in the average case; is that not true? A. Yes, some medications are used by people providing D&E procedures. It depends on the specific **[96]** facility and clinician as to what's provided.

Q. In your best medical judgment, don't you agree that the hospital pharmacy is more likely to be more completely able to resolve the medication needs of its abortion patients than are the average abortion clinic pharmacies? A. It depends on what the routine protocol is. Again, since we are speculating, I mean I could think of a situation where a busy hospital pharmacy might be more likely to mix up routine orders than an abortion facility that only has specific drugs available to it. For example, oxytocic type drugs or routine type antibiotics given postoperatively or even premedications before the procedure. As far as having a breadth of drugs available to it, certainly a hospital pharmacy would have more than a nonhospital facility.

Q. Are there any statistics that you know of that lend any validity at all to your hypothesis that a drug mixup in hospitals could have a deleterious effect on the health interests of women having abortions in hospitals? A. No. I have no data upon which to base that speculation, and I underline that word just as strongly as you did. [101] Q. Now, am I correct in the way in which I speak of D&E and curettage, that curettage refers to an evacuation procedure performed within the first trimester? A. That is generally the terminology that we use for these procedures.

Q. And D&E's, then, under your terminology are evacuation procedures performed at 13 weeks and thereafter? Is that correct? A. That's correct.

Q. Isn't it true that complications resulting from D&E's are more frequent and more severe than those from curettage procedures at early stages? A. Yes, it is.

Q. I think we went into this briefly before, Doctor, but I want to make it very clear. You understand, do you not, that physicians are not required by any law I know of — perhaps you can correct me if [102] you know it — to determine to use any one particular type of abortion technique in mid-trimester? A. That's correct.

Q. And we agree, do we not, that if the abortion in the second trimester is to be done by saline instillation, it should be done in the hospital; at least a portion of it involving delivery should be done in the hospital? A. Yes. That's my current feeling.

Q. And do we agree that a second-trimester abortion performed by the instillation of prostaglandin should be performed in a hospital? A. Yes. That's correct.

Q. And do we not also agree that a second-trimester abortion performed by hysterotomy should be performed in a hospital? A. Very definitely.

Q. Can we not also agree that a second-trimester abortion performed by other instillation techniques — that is, other than saline and prostaglandin — should be performed in hospitals? A. I agree.

Q. Now, sudden death has resulted from each of these types of abortion techniques in the second trimester? **[103]** A. Yes.

Q. And sudden death also has resulted from the use of D&E at mid-trimester? A. Yes, depending upon how you categorize the word "sudden." But that's all right.

Q. Well, don't you use the term "sudden" in your own report someplace? A. That death can occur soon after the procedure, if immediate care is not taken to remedy emergency situations, with any abortion technique.

Q. Now, Doctor, I want to understand your position on the second-trimester requirement that many states have, second-trimester hospitalization requirement. Do I correctly summarize your position that second-trimester requirement in those states is valid and reasonable with respect to all abortion techniques except dilatation and evacuation, that the second-trimester requirement is valid and acceptable at the present state of knowledge, based on your statistics, now only at 16 weeks and thereafter but not at 13 to 15 weeks; is that a fairly accurate summary of your position on those types of studies? A. As a blanket statement, yes. But again I wish to emphasize that drawing gestational age thresholds should be amenable to change in order to **[104]** advance techniques and improve the safety of the procedures.

Q. I understand that, Doctor. Didn't we also agree earlier, and in your most recent statistics in 1978 that of all second-trimester abortions performed, only 51 percent were by dilatation and evacuation? A. That is correct.

Q. When saline is used, is it not true that clotting can become a serious complication? A. Yes, that is right.

Q. And, if that were to occur, it would be best treated in the hospital, would it not? A. yes, it would.

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[105] Q. Dr. Cates, I want to give you a hypothetical [106] example of an abortion performed at 26 weeks. The fetus would be more likely to survive that abortion if prostaglandin were used as opposed to saline, would it not? A. That is correct.

Q. And certainly it would be more likely to survive an abortion if either prostaglandin or saline were used as opposed to D&E? A. That is also correct.

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[107] A. (Continuing) As far as the question asked, let me just answer that I personally have lots of difficulty with abortions performed at 26 weeks. I really have lots of trouble with abortions performed at gestational age thresholds perhaps even lower than 26 weeks, and I have not completely resolved the issue nor do I suspect I ever will completely, as medical science is more able to sustain life outside the womb, as to what the appropriate gestational age, if any, should be on pregnancy termination, as far as personal morals.

Q. You state the dilemma the same way I see it, Doctor. Doctor, at the present time are there any studies that indicate the long-term effects of second-trimester D&E abortions on future pregnancies? A. That's an excellent question. Unfortunately we only have really anecdotal reports to date regarding [108] the experience of some practitioners looking at the effects of instrumental evacuations on future childbearing on women who undergo that. There is one, again, bit of provisional data coming out of Sweden to imply that, in abortion procedures in which mechanical dilatation was used that was greater than 13 millimeters, that there may be increased risk of shortened gestation in future pregnancies. Again, let me emphasize that the studies of long-term effects of induced abortion based on first-trimester procedures have been generally inconsistent when conducted in this study with the results found in other studies in other countries. So I'm not exactly sure what to make of this provisional data showing increased risk of shortened gestation with later procedures. And, moreover, many of the D&E procedures being done in this country are being done with lamanaria as a preoperative cervical dilator, and it may be that that would protect against any alleged long-term complications that are still in the hypothesis stage.

Q. Dr. Cates, is the comparative skill of the clinician statistically taken into acount with respect to your numbers relating to D&E's and other methods of abortion performed in this country? [109] A. No, it is not. The operative skill for any surgical procedure, whether it's an abortion, whether it's a Caesarean section, whether it's a cholecystectomy or whether it's a coronary bypass, is a largely unmeasurable factor. It's been looked at a number of times in a number of circumstances by a level of operator training, by number of procedures performed, and in fact the best measure, I facetiously say, of an operator's skill is the star under which he or she is born. And in reality that's the great variable and the reason why I maintain that it's probably more important to continue to monitor the outcome, the results of the complications of a particular procedure rather than to base it on any ongoing objective criteria such as board certification status or what have you. That can be a start. But continued monitoring is necessary in order to maintain operator skill.

Q. There do presently exist methods by which to objectively assess the clinical skill of members of staffs of hospitals, are there not? I'll give you some examples. Peer study groups; the staff group that is there to review selected medical files; medical review committees in hospitals; JCAH accreditation and evaluation. Those are ways in which [110] staff members of hospitals are objectively evaluated; is that not true? A. Insofar as they are measures of one sort of another, you can perhaps call them objective. Whether or not they are valid, and whether or not they accurately measure the skill involved is still another question that I'm not prepared to defend.

Q. Well, they are at least an attempt by the medical community to be objective, are they not? A. They are certainly one attempt to be objective. Once again, of course, the peer review system of process measurement, which might be the experience of the operator, or board certification of the operator, are also taken into account in our review of the data base that we talked about earlier — namely, the abortion deaths. We go through a peer review system in investigating and analyzing all of these deaths. But nonetheless, in talking about the term "operator skill," again, I think that's a largely unquantifiable element within our epidemiologic capacity to measure.

Q. I agree it's difficult, Doctor. But do you know of any procedures which are designed to be objective, similar to the ones that we've discussed for hospital staffs, which exist to evaluate, on a [111] supposedly objective basis, the clinical skill of those people who perform abortions in abortion clinics? A. Again, traditionally most people have relied on either board certification status, the number of procedures performed, apprenticeship type situations. What I would prefer to see is, of course, continued monitoring of each individual practicing with an eye towards seeing whether or not any particular individuals are having higher complication rates or more frequent problems with procedures. In other words, a focus from what I call process or structured type measurements to ones that are based on outcome measurements.

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[112] Redirect Examination

By Mr. Susman:

Q. Would that range also not exist in the quality of care within hospitals, from good to bad? [113] A. yes, it would.

Q. Does the fact that an institution is a hospital somehow automatically mandate good quality care or insure it? A. It doesn't necessarily mandate it, no.

Q. Does it insure it? A. It doesn't necessarily insure it, either.

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Q. You've indicated that you would like to see some kind of regulation based upon proven ability before one advances to doing abortions at later stages [114] of gestation? A. Yes, that's correct.

Q. Would you like to see the same state regulations for all surgical procedures; you would have to show, first of all, that you are competent to do the ones that are easier and have less complications before you could advance to later states? Do you think the state should be involved in that kind of regulation in all matters of surgery? A. No, I do not. This has to do, really, with a personal philosophy rather than a professional opinion about which I have data. It has more to do with the idea that what we attempted to do is to challenge what I feel might be excessive regulation by posing a 12-week threshold and substituting a compromise threshold that would be more based on the advances in medicine that have taken place since the initial threshold had taken place. I don't want to be in the position of advocating intense regulation of all medical services.

Q. Why do you single out abortion for regulation? A. Abortion has been singled out, for better or for worse, because of its controversial aspect or controversial nature, and, because of that, it is [115] subject, in my opinion, to more intense public health scrutiny than any other surgical procedure in the United States. And we know more about abortion than any other surgical procedure in the United States.

Q. Are you saying, then, that you recommend the graduated regulation based on competence in the field of abortion only as a reaction to existing more stringent regulations?

Mr. Boicourt: I object as leading. Counsel is testifying for the witness.

By Mr. Susman:

Q. You may answer the question. A. It's a good question. I basically feel that abortion is different than most other surgical procedures because of the intense public interest in it. For that reason, providers should be aware that their particular records will be subject to more scrutiny, and they should, in my opinion, take special care to document their particular track records with regard to safety.

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[117] Q. Doctor, does an inhospital requirement after 12 weeks insure any greater degree of health and safety for women, such a blanket requirement? A. No, not after 12 weeks. Possibly up to 16.

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[119] Q. Based upon all the considerations which I stated in the prior question, is it reasonable to believe that it is safer to do D&E's inhospital than it is outpatient? A. No. Again the data indicates that up through 16 weeks it is not safer to perform D&E's in hospital settings than in nonhospital settings.

Q. Sixteen weeks — that would be 18 weeks' gestation; correct?

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[120] A. We don't have specific information regarding the health effects on women forced to travel because they were unable to D&E's of which I'm aware. There are some data that tend to show that women who have to travel are less likely to obtain abortions, which is not the same as saying they are more likely to suffer complications.

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[121] Q. Doctor, do you consider a blanket requirement that all abortions after 12 weeks be performed in a hospital to be rationally related to maternal health? A. No, I do not for reasons I enunciated earlier.

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Recross Examination

By Mr. Boicourt:

Q. Doctor, I want to make sure I understand. We have been talking about 16 weeks, for example, which is one of the breakoff points, and 16 weeks of gestation. There are two different ways of counting that. We've been doing it a certain way? A. Right.

[122] Q. What is that way? A. We've been using it in terms of weeks after last menstrual period.

Q. Is there another way of doing it? A. The other way referred to in earlier testimony was in terms of gestational weeks, and that tends to mean dates or weeks after conception, which, in standard terminology, occurs two weeks later. The conception occurs two weeks later than the menstrual period. So therefore the dates are two weeks shorter. Conception weeks are two weeks shorter.

Q. So when we were speaking of 13 to 15 weeks and the safety of D&E procedures during those weeks, if you use the other figures, we are talking about 11 to 13 weeks? A. Correct.

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[126] Q. I understand. But what you were actually saying was that you object to the blanket requirement because it would require D&E procedures at 13 to 15 weeks to be performed in a hospital, and you don't think the statistics justify that requirement? A. That is the predominant reason; what the data show.

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[127] Q. Then, Doctor, isn't it true, then, that for those 49 percent of all abortions which were performed by various forms of instillation and that for abortions performed at 16 weeks and thereafter, certainly by 18 or 19 weeks, by D&E techniques, for abortions performed by hysterotomy, that a requirement [128] that those abortions be performed inhospital is rationally related to concern for maternal health? A. I believe, yes, that those were the procedures that were available back in '73 and the court was acting reasonably considering the data it had available to it at that time. but with new data, that 12-week threshold needs to be opened up.

Q. And all those procedures are still covered by the blanket 12-week prohibition, are they not? A. All those procedures are covered by the 12-week prohibition.

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Deaths from Second Trimester Abortion by Dilatation and Evacuation: Causes, Prevention, Facilities

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Submitted for publication June 10, 1981.

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Dilatation and evacuation (D & E) has emerged as the leading method of second trimester abortion in the United States. In 1978, D & E accounted for 51% of all abortions at 13 weeks' gestation or later. Over three quarters (77%) of D & E procedures are performed in the 13-to-15 week gestation interval, although 20% are performed in the 16-to-20 week interval, and 3% at the 21 weeks' gestation or later.

The increased popularity of D & E for second trimester abortion reflects its relative advantages in safety, convenience, expense, and speed when compared with alternative methods. Over the past 6 years, numerous case series, prospective observational studies and 1 randomized clinical trial have documented the superiority of D & E to other second trimester procedures.

Despite these reported advantages, some authorities believe that widespread use of D & E by physicians inexperienced in this technique may increase the risks of the procedure. Others believe that second trimester D & E is so risky that it should only be performed in hospitals. They predict that increasing use of D & E in nonhospital facilities will cause an increase in the incidence of deaths and complications.

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Methods

Abortion-related deaths were identified through the Centers for Disease Control's ongoing surveillance of abortion mortality, the methods of which have been described in detail previously. D & E procedures are defined as those transcervical evacuation methods performed at 13 menstrual weeks' gestation or later. These procedures frequently involve using a combination of instruments: vacuum equipment, a sharp curette, and special forceps. Gestational age for each procedure in which a woman died was determined by postoperative measurements of fetal size, rather than by less objective preoperative estimates. Using these postoperative objective measures, the duration of gestation is expressed as completed menstrual weeks throughout the report.

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Deaths:Case Rates

In the United States for the 7 years between 1972 and 1978, D & E methods had an overall death:case rate of 7.7 per 100,000 procedures (Table 2). Age had little effect on the risk of dying from D & E. Women over 30 had a slightly higher death:case rate than younger women, but the difference was small and not statistically significant ($P > .30$).

However, both race and gestational age significantly influenced the death:case rate for D & E procedures. White women had a threefold lower risk than women of other races of dying from D & E. D & E procedures . . . performed at 13 to 15 weeks' gestation were nearly 3 times safer than those performed at 16 weeks or later.

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Table 2. Death : Case Rates for Dilatation and Evacuation Procedures, by Woman's Age, Race, Weeks' Gestation, and Type of Facility in the United States Between [illegible] and [illegible]

Characteristic	No. of deaths	Estimated no. of procedures	Death : case rate*
Woman's age			
≤ 19	7	103,100	6.8 (3-14)
20-29	8	105,400	7.6 (3-15)
≥ 30	3	25,800	11.6 (2-34)
Race			
White (including Hispanics)	7	154,700	4.5 (2-9)
Black and other	11	79,600	13.8 (7-25)
Gestational age (wk)			
13-15	10	177,300	5.6 (3-10)
≥ 16	8	57,000	14.0 (6-29)
Type of facility			
Clinic	11	160,200	6.9 (3-12)
Hospital	7	74,100	9.4 (4-20)
Total	18	234,300	7.7 (5-12)

* Deaths per 100,000 procedures. The 95% confidence limits are in parentheses.

When D & E was compared with other abortion methods, its death:case rate was found to be higher than that of curettage procedures performed earlier in gestation, but lower than rates of the other second trimester alternatives (Table 3). The death:case rates were 1.0 per 100,000 procedures for curettage abortions performed at 12 weeks' gestation or earlier; 12.3 for the second trimester instillation procedures; and 42.9 for hysterotomy/hysterectomy procedures. However, because the risk of death from D & E is directly related to gestational age, the death:case rate in the 13-to-15-week interval (5.6/100,000) is significantly ($P < .05$) less than at 16 weeks' gestation or later (14.0/100,000). Thus, the lower risk of dying from D & E in the 13-to-15-week period. After 15 weeks' gestation, the death:case rates for D & E and instillation agents are guite similar (Table 3).

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Table 3. Death : Case Rates by Type of Abortion Method and Gestational Age in the United States Between 1972 and 1978

Type of method and gestational age	No. of deaths	Estimated no. of procedures	Death : case rate*	95% CL†
D & E (≥ 13 weeks)	18	234,300	7.7	5–12
13–15 weeks	10	177,200	5.6	3–10
≥ 16 weeks	8	57,000	14.0	6–28
Curettage (≤ 12 weeks)	53	5,385,200	1.0	0.7–1.3
Instillation (≥ 13 weeks)	50	405,900	12.3	9–16
Saline	38	273,000	13.9	10–19
Prostaglandin and other agents	12	132,900	9.0	5–16
Hysterotomy/hysterectomy	9	21,000	42.8	20–81

* Deaths per 100,000 procedures.

† 95% confidence limits.

Some clinicians emphasize that deaths from D & E could have been prevented if the procedure had been performed in hospitals rather than in clinics. For example, the 4 women who died from internal hemorrhage after uterine perforation in a nonhopital facility might have benefited from immediate availability of blood bank services. Yet, performing D & E procedures in hospitals does not provide complete protection; 3 of the 7 deaths from hemorrhage after D & E occurred in hospitals with blood banks.

These data do not support regulations in some states requiring all second trimester abortions to be performed in hospitals. These laws were encouraged by the Supreme Court's decision on abortion in 1973, which allowed states to regulate second trimester abortions in the interests of the woman's health. Data forming the basis for this decision were collected before 1972, when the available second trimester methods were primarily saline instillation and hysterotomy. Since 1973, however, abortion techniques have improved, physicians have accumulated greater experience, and the concept of trimester threshold for uterine evacuation procedures has been largely abandoned. Case series have demonstrated that some physicians can safely perform D & E in nonhospital facilities, thus decreasing the cost and increasing the convenience for the woman. The comparative mortality data indicate that performing D & E outside of hospitals carries no greater risk of death. Thus, it is time to reconsider restrictive regulations that have not kept pace with medical practice.

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The data do not identify the appropriate gestational age limit for requiring that all abortions be performed in hospitals. One practitioner has reported safely performing D & E through 20 weeks' gestation in nonhospital settings. To require the physician to perform his procedures in hospitals might only increase the costs without improving the safety. However, as a general rule, it is reasonable to perform procedures with death:case rates of approximately 10/100,000 or less outside the hospital; this level of risk would include such common procedures as tonsillectomy, laparoscopic tubal sterilization, and diagnostic dilatation and sharp curettage. For D & E, this would permit moving the threshold for required hospitalization from 12 to 16 weeks' gestation. As abortion techniques and physicians' skills improve further, the threshold could be slowly advanced. Proposed changes should be based on scientific evidence gathered through ongoing surveillance, however, rather than on unsubstantiated opinions.

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ANNUAL SUMMARY 1978
Issued November 1980

CENTERS FOR DISEASE CONTROL

ABORTION

SURVEILLANCE

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES • Public Health Service

I. SUMMARY

In 1978 the 50 states and the District of Columbia reported 1,157,776 legally induced abortions to the Center for Disease Control, a 7% increase over 1977. The national abortion rate rose from 22 per 1,000 females aged 15-44 in 1977 to 23 in 1978. The national abortion ratio increased by 7%, from 325 to 347 per 1,000 live births, or more than 1 abortion for every 3 live births.

As in previous years, women who obtained abortions in 1978 were most often young, white, unmarried, and of low parity. Sixty-five percent were less than 25 years of age; 67% were white, and 33% were black and other races. Seventy-four percent of all women obtaining abortions were unmarried at the time of the procedure, and 57% had had no live births. Curettage continued to be the most widely used procedure for reported legal abortions, accounting for 95% of abortions performed in 1978. Compared with 1977, the percentage of saline instillation procedures used after 15 weeks' gestation decreased, dilatation and evacuation procedures increased, and instillation of prostaglandin and other agents remained the same.

Women continued to seek abortions at earlier gestational ages; over half (52%) of all abortions were performed at less than 9 menstrual weeks' gestation, and 91% of abortions were induced within the first 12 weeks. Younger women obtained abortions at later gestations than older women. Nearly half (46%) of the abortions performed after 15 weeks of gestation were to women 19 years of age or younger. A woman's race had relatively little impact on the gestational age when she obtained an abortion.

In 1978, 27 women died from abortion, 8 fewer than the 35 who died in 1977. Compared with 1977 there was a decline in the annual number of legally induced abortion deaths; 11 women died after legally induced abortion in 1978, compared with 17 in 1977, 11 in 1976, and 31 in 1975. Four of the 11 deaths in 1978 were due to ectopic pregnancy after attempted legally induced abortion. In 1978 there were 7 deaths after illegally induced abortion and 9 deaths after spontaneous abortion. The death-to-case rate for legally induced abortions decreased from 1.4 in 1977 to 0.6 per 100,000 abortions in 1978.

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J. Weeks of Gestation

In 1978 more than half (52%) of reported legal abortions were performed in the first 8 weeks of gestation (Summary Table). The majority (91%) of abortions were performed at less than 13 weeks' gestation. Approximately 4% of women obtained abortions in the 13- to 15-week interval and in the 16- to 20-week interval and only 1% at greater than 20 weeks. These proporations continue the trend noted since 1972 of an increase in the percentage of reported legal abortions performed at less than 9 weeks' gestation with a corresponding decrease in the percentage of abortions performed at later gestational ages (Summary Table). Although the proportion of abortions performed in the first and second trimesters remained the same in 1978 as in 1977, abortions were performed earlier in both trimesters (less than or equal to 8 weeks and 13-15 weeks, respectively). Thirty-seven states and the District of Columbia reported information on gestation at the time of abortion, comprising 66% of all reported abortions (Table 12).

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L. Weeks of Gestation by Type of Procedure

In 1978 currettage (suction and sharp) continued to be nearly the only method used (99%) for pregnancy termination in the first 12 weeks' gestation (Table 14). Thirty-two states reported information on weeks of gestation by type of procedure, accounting for 50% of all reported abortions in 1978. In the 13- to 15-week interval, 82% of all procedures were by curettage instillation (4%). Saline instillation was the most commonly used method for both at 16-20 weeks' gestation (46%) and greater than or equal to 21 weeks (53%), with instillation of prostaglandin or other agents (e.g., urea) and D&E accounting for about 30% and 22%, respectively, in 1978. Compared with 1977, the percentage of saline instillation procedures used after 15 weeks' gestation decreased, D&E procedures increased, and instillation of prostaglandin and other agents remained the same. Since 1974, saline instillation after 15 weeks' gestation has decreased (from 71%), whereas D&E procedures and instillation of prostaglandin and other agents have increased.

M. Weeks of Gestation by Age Group

Younger women obtained abortions at later gestations than older women (Table 15). In 1978, 31 states reported data on weeks of gestation by age, accounting for 49% of all reported abortions. Over half the women in all age groups 20 or older obtained abortions in the first 8 weeks of gestation (Table 15). The tendency to obtain abortions at earlier gestational ages generally increased with the age of the woman, peaking in the 30- to 34-year-old age group. Almost 14% of abortions to women 19 years of age or younger occur after the first 12 weeks, compared with 7.4% of those to women 20 years or older. Women 19 years of age or younger appear twice as likely to obtain abortions after 16 weeks' gestation (7.3% compared with 3.7%for women 20 years of age or older) and account for almost half (46%) of the abortions performed after 16 weeks' gestation.

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Table 12
Reported Legal Abortions, by Weeks of Gestation* and State of Occurrence, Selected States,† 1978

State	≤ 8 No.	≤ 8 %	9-10 No.	9-10 %	11-12 No.	11-12 %	13-15 No.	13-15 %	16-20 No.	16-20 %	≥ 21 No.	≥ 21 %	Unknown No.	Unknown %	Total No.	Total %
Alaska	81	12.1	252	37.7	212	31.7	47	7.0	5	0.7	2	0.3	70	10.5	669	100.0
Arizona	2,938	43.0	2,150	31.5	1,073	15.7	356	5.2	130	1.9	5	0.1	181	2.6	6,833	100.0
Arkansas	3,240	64.6	948	18.9	458	9.1	106	2.1	220	4.4	28	0.6	14	0.3	5,014	100.0
Colorado	5,332	34.6	4,407	28.6	2,358	15.3	1,350	8.8	980	6.4	377	2.4	593	3.9	15,397	100.0
Connecticut[1]	6,169	44.8	4,873	35.4	2,069	15.0	106	0.8	211	1.5	16	0.1	340	2.5	13,784	100.0
Dist. of Col.	19,550	65.6	5,896	19.8	1,922	6.5	789	2.6	599[2]	2.0	151[2]	0.5	879	3.0	29,786	100.0
Georgia	15,467	44.6	10,251	29.6	4,878	14.1	1,327	3.8	1,708	4.9	1,026	3.0	0	0.0	34,657	100.0
Hawaii	3,522	58.6	1,343	22.3	575	9.6	215	3.6	310	5.2	38	0.6	11	0.2	6,014	100.0
Idaho	981	46.6	648	30.8	351	16.7	53	2.5	6	0.3	2	0.1	66	3.1	2,107	100.0
Illinois	36,681	52.5	19,056	27.3	9,445	13.5	3,137	4.5	970	1.4	182	0.3	358	0.5	69,829	100.0
Indiana[1]	8,022	66.8	2,742	22.8	899	7.5	83	0.7	16	0.1	1	0.0	240	2.0	12,003	100.0
Kansas	3,584	38.8	2,556	27.7	1,447	15.7	723	7.8	656	7.1	230	2.5	33	0.4	9,229	100.0
Louisiana	5,157	45.9	3,338	29.7	2,225	19.8	303	2.7	150	1.3	7	0.1	56	0.5	11,236	100.0
Maryland	13,311	53.9	6,398	25.9	3,046	12.3	713	2.9	1,079	4.4	134	0.5	0	0.0	24,681	100.0
Massachusetts	22,976	57.2	10,648	26.5	3,912	9.7	966	2.4	1,432	3.6	266	0.7	0	0.0	40,200	100.0
Minnesota	5,792	33.6	5,599	32.4	3,168	18.4	1,495	8.7	1,143	6.6	65	0.4	0	0.0	17,262	100.0
Mississippi	1,330	40.5	1,101	33.6	562	17.1	140	4.3	27	0.8	8	0.2	112	3.4	3,280	100.0
Missouri	5,449	35.1	5,516	35.5	3,009	19.4	875	5.6	351	2.3	79	0.5	240	1.5	15,519	100.0
Montana	1,198	39.4	1,009	33.1	462	15.2	114	3.7	41	1.3	--	--	220	7.2	3,044	100.0
Nebraska	1,377	28.5	1,654	34.2	1,159	24.0	436	9.0	181	3.7	19	0.4	11	0.2	4,837	100.0
Nevada	3,749	79.2	734	15.5	150	3.2	16	0.3	51	1.1	3	0.1	31	0.7	4,734	100.0
New Hampshire	646	28.1	888	38.6	497	21.6	63	2.7	80	3.5	4	0.2	122	5.3	2,300	100.0
New Jersey	17,208	60.5	6,179	21.7	2,897	10.2	853	3.0	898	3.2	104	0.4	292	1.0	28,431	100.0
New Mexico	2,231	46.9	1,265	26.6	556	11.7	400	8.4	171	3.6	3	0.1	126	2.7	4,752	100.0
New York	77,359	50.3	39,354	25.6	17,489	11.4	7,706	5.0	8,628	5.6	2,698	1.8	469	0.3	153,703	100.0
(City)	(55,763)	(52.7)	(25,664)	(24.2)	(11,130)	(10.5)	(5,241)	(5.0)	(5,695)	(5.4)	(2,126)	(2.0)	(218)	(0.2)	(105,837)	(100.0)
(Upstate)	(21,596)	(45.1)	(13,690)	(28.6)	(6,359)	(13.3)	(2,465)	(5.1)	(2,933)	(6.1)	(572)	(1.2)	(251)	(0.5)	(47,866)	(100.0)
North Carolina	10,366	38.0	8,170	30.0	4,122	15.1	1,539	5.6	1,285	4.7	192	0.7	1,592	5.8	27,266	100.0
Ohio	23,093	55.7	4,229	10.2	1,054	2.5	606	1.5	861	2.1	--	--	11,604	28.0	41,447	100.0
Oregon	4,917	36.1	4,685	34.4	2,556	18.8	781	5.7	562	4.1	77	0.6	27	0.2	13,605	100.0
Pennsylvania	35,403	58.4	14,991	24.7	5,976	9.9	1,674	2.8	2,147	3.5	327	0.5	121	0.2	60,639	100.0
Rhode Island[1]	2,461	54.7	1,320	29.4	494	11.0	29	0.6	186	4.1	0	0.0	7	0.2	4,497	100.0
South Carolina	4,833	48.5	2,898	29.1	1,635	16.4	477	4.8	104	1.0	20	0.2	2	0.0	9,969	100.0
South Dakota	622	44.6	265	19.0	181	13.0	154	11.0	150	10.7	21	1.5	3	0.2	1,396	100.0
Tennessee	8,619	45.6	6,031	31.9	3,231	17.1	682	3.6	215	1.1	41	0.2	70	0.4	18,889	100.0
Utah	1,409	45.0	1,056	33.7	383	12.2	242	7.7	2	0.1	0	0.0	38	1.2	3,130	100.0
Vermont	1,527	59.0	688	26.6	269	10.4	86	3.3	12	0.5	3	0.1	3	0.1	2,588	100.0
Virginia	16,315	53.6	8,628	28.3	3,157	10.4	656	2.2	1,257	4.1	156	0.5	273	0.9	30,442	100.0
Washington	15,588	52.2	8,809	29.5	3,730	12.5	491	1.6	1,036	3.5	116	0.4	78	0.3	29,848	100.0
Wyoming	366	51.1	236	33.0	73	10.2	18	2.5	13	1.8	--	--	10	1.4	716	100.0
Total	388,829	50.9	200,831	26.3	91,680	12.0	29,807	3.9	27,873	3.6	6,401	0.8	18,312	2.4	763,733	100.0

[1] Weeks of gestation based on physician's estimate

[2] Reallocation of reported abortions into comparable categories based on percentage distribution of abortions by single weeks of gestation reported from 32 states

*Weeks from last menstrual period

†All states with data available (38)

Table 20

Death-to-Case Rate for Legal Abortions, by Weeks of Gestation, United States, 1972-1978

Weeks of Gestation	Deaths[1]	Abortions[2]	Rate[3]	Relative Risk[4]
≤ 8	13	2,749,725	0.5	1.0
9-10	24	1,705,478	1.4	2.8
11-12	20	883,932	2.3	4.6
13-15	20	300,186	6.7	13.4
16-20	47	338,488	13.9	27.8
≥ 21	12	68,584	17.5	35.0
Total	136	6,046,393	2.2	

[1] Excludes deaths from ectopic pregnancy

[2] Based on distribution of 4,292,615 abortions (71.0%) with weeks of gestation known

[3] Deaths per 100,000 abortions

[4] Based on index rate for ≤8 menstrual weeks' gestation of 0.5 per 100,000 abortions

Table 22
Legal Abortion Deaths* by Type of Procedure and Weeks of Gestation, United States, 1972-1978

Type of Procedure	Weeks of Gestation						
	≤ 8	9-10	11-12	13-15	16-20	≥ 21	Total
Curettage	12	22	19				53
Dilatation and evacuation				10	7	1	18
Instillation				5	36	9	50
(Saline)				(1)	(31)	(6)	(38)
(Prostaglandin)				(3)	(5)	(1)	(9)
(Other agents)				(1)	(0)	(2)	(3)
Hysterotomy/ Hysterectomy	0	2	1	3	2	1	9
Other[1]	1	0	0	2	2	1	6
Total	13	24	20	20	47	12	136

[1] Includes 2 deaths with unknown type of procedure, 1 at 13-15 weeks and 1 at 16-20 weeks of gestation

*Excludes deaths from ectopic pregnancy

Table 23
Death-to-Case Rate* for Legal Abortions, by Type of Procedure and Weeks of Gestation United States, 1972-1978

Type of Procedure	Weeks of Gestation						Total
	≤ 8	9-10	11-12	13-15	16-20	≥ 21	
Curettage	0.4	1.3	2.3				1.0
Dilatation and evacuation				5.6	14.1	13.5	7.7
Instillation	0.0	0.0	0.0	8.2	14.2	19.5	12.3
(Saline)	(0.0)	(0.0)	(0.0)	(2.2)	(17.6)	(17.1)	(13.9)
(Prostaglandin and other agents[1])	(0.0)	(0.0)	(0.0)	(24.8)	6.4)	(26.7)	(9.0)
Hysterotomy/ Hysterectomy	0.0	55.5	37.2	68.3	45.2	147.3	42.8
Total[2]	0.4	1.4	2.4	8.2	15.2	22.1	2.2

[1] Denominators for rates include abortions reported as type of procedure "other" (1% of all abortions with procedure known)

[2] Includes deaths with type of procedure "other" (4) and unknown (2)

*Deaths per 100,000 abortions; based on distributions of abortions with type of procedure and weeks of gestation known

[5] TRANSCRIPT OF PROCEEDINGS
(October 15-20, 1979)

JUDITH A WIDDICOMBE,

called as a witness, being duly sworn, testified:

Direct Examination by Mr. Susman:

* * * * * * * *

[12] A. Approximately one-third of women coming to Reproductive Health Sevices are in the 19 and under category.

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Q. (By Mr. Susman) Can you tell us then on a further breakdown of what approximate percentage the patient population of Reproductive Health Services is under the age of 18? A. About 85 per cent of that.

Q. Eighty-five per cent of the one-third? A. Yes.

* * * * * * * *

[17] Q. Are you aware as to the prevalence or incidence of second trimester abortions being performed by the method of D & E, dilatation and evacuation, six years ago in 1973? A. There were very few. The major procedure of choice was no termination from 13 to 15 weeks, and somewhere in the 15th week then the procedure of choice was saline aminoinfusion.

* * * * * * * *

[19] A. Because it has a number of benefits for the patient. Number one, it is a very simple procedure. It takes about 15 or 20 minutes. There is no dalay involved. If she is too far to be

done as a first trimester patient, she then [20] becomes a D & E patient and at the same facility it would not mean changing a support system that has already been developed. Changing physicians. Obviously, the cost is much less than going into a hospital. Another important item is that the risk to her health and life is less, because by staying in an ambulatory setting, the procedure could be done with a local anesthesia, wherein a large majority of cases in a hospital the same procedure is done with the administration of a general anesthesia which increases yet another respiratory risk to the patient.

* * * * * * *

[21] Q. Through your experience, are you also familiar with the types of complications that may arise through the D & E procedure? A. Yes. I have observed those also.

[22] Q. Are those types of complications those that are routinely handled and capable of being handled in an out-patient facility? A. Yes. The basic complications that I have observed with second trimester D & E are basically the same complications that occur with first trimester suction curettage. We are still talking about the same kind of evasive procedure of the uterus, and the uterus just happens to be a bit bigger in the second trimester than in the first.

Q. Are you also aware of the hospital costs of obtaining the D & E procedure, the stages in which you are talking about? A. Yes.

Q. What do those generally run? A. Those run anywhere from $450 to $1,000.

Q. Are you aware of what the prevailing charge for a second trimester D & E procedure in an outpatient facility is in the United States? A. It is around $250 to $300.

Q. So anywhere between a half to a third as much is required to go into the hospital? A. Yes, and that is only the economic cost.

Q. I am not sure I know what you mean by that. A. The social cost to the patient is considerably less because it does not require hospitalization. So it does not [23] require social costs to her family for being gone an extensive time, two to three days. So that cost is less. So the direct money exchange is exceedingly less, and so is the cost to her family as a piece of the family unit.

Q. Are you saying the average hospital stay for a second trimester D & E procedure under 18 weeks is two to three days? A. Yes.

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[24] A. There are a number of questions. In the past, part of the problem has been when parental consent was required that there was a delay because of the young person not wanting to involve the parent. The other thing is an inability of a young woman to accept the fact that she may in fact be pregnant.

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[25] A. Availability is a very important issue. Where to go, how to get there, all of the compounding problems of a minor seeking services. Probably denial is one of the most important things, and the requirement of parental consent being the second.

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[48] Q. Are there a certain number of abortion procedures in which pathology is requested and obtained? A. Yes.

Q. Approximately what percentage? A. Approximately 12 per cent.

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A. A microscopic exam — a gross examination of all of the tissue that has been removed —

Q. By gross exam, are you referring to a visual — A. A visual eye exam.

Q. Without the aid of enlargement or microscope? A. That is correct. A microscopic exam, which is that tissue examined under a microscope is determined by the physician based on the tissue that is removed during the procedure itself. It could be a patient who gives a menstrual [49] history, and the tissue that is removed is incompatible, which could indicate the potential extra-uterine implantation which we discussed earlier, an ectopic pregnancy, and it would be sent to pathology for specific items that the pathologist would be looking for that would be used in further diagnosis by the physician.

It could be that the tissue was abnormal in some respect. It could be that it was what is termed & blighted ovum.

It could be that it was grape-like clusters that are visible by the naked eye that could represent a malor pregnancy, which is in many cases precarcinogenic. Then the patient needs appropriate follow-up care.

And it could be just that the physician felt that something was not right and so he asked that it be sent to pathology.

Q. As I understand your testimony, the tissue in every procedure is examined grossly by the physician and then he makes the determination as to whether or not he believes a further microscopic examination is desired in that particular instance, based on any nubmer of factors to be done by a pathologist, is that correct? A. That is correct.

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[50] A. We are currently paying $20, and the cost can be as high as $35, depending on the kind of examination you are looking for.

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Q. Does it specify in this section whether or not the pathologist must perform a gross or microscopic exam? A. No, it is very vague.

Q. So, in other words, this section would allow the pathologist to perform a gross exam. It merely says it will be submitted to him, is that correct? A. That is correct.

[51] Q. That gross exam would be the same as the gross exam presently performed by your physician? A. That is correct.

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Q. In your familiarity with outpatient abortion facilities, based on your experience previously described, as they presently exist within the United States, is it the practice of outpatient facilities in this country, in cases where not required by similar sections,to perform pathology on every abortion patient? A. No, it is not standard practice.

Q. Do you feel this provision burdens or interferes with the relationship between the patient and medical facility? A. Yes, it does.

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[61] Cross Examination by Mr. Boicourt:

[70] Q. But at the present state of technology, isn't it true that there is more likely to be a need for a blood transfusion during the second trimester abortion than during a first trimester abortion? A. No, I cannot honestly say that is true.

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[71] A. Your question I interpret as in two parts. The answer to the first question, Mr. Boicourt, is having worked in a hospital a lot of time we have had dramatic problems with infection and the spread of infection in a hospital. **[72]** In seven years of experience that has never happened at Reproductive Health Services, so we have better quality control.

Yes, in the event of a severe infection, that may, in fact, be a hospital procedure, but we are talking about an abortion-procedure, and if there is an infectious process that develops, it will be much later, after 72 to 96 hours.

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[74] Q. I believe you've testified to your belief that that was the safest form of second trimester abortion for the woman, is that correct? A. That is correct.

Q. Isn't it also true that necessarily by the use of that technique it is impossible for the fetus to survive? A. That is correct.

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[100] Q. Have you ever observed a physician doing what you call a gross examination of tissue? A. Yes.

Q. How does he do that? A. He does that by after the products of conception have been removed, by putting it either in an emesis basin or petri dish. He can examine the tissue, fetal and placental tissue, to see whether or not the products of conception are there. What he has removed, he looks at it. It may be molar, as we discussed this morning. It may be minimum tissue and suggests ectopic. He is looking at volume.

Q. Is it in a bottle or dish? Does he just look at it? A. An emesis basin is a kidney-shaped basin that has a bottom to it. He looks through it with his hands. A petrie dish is a round glass dish that is used in laboratories that agar is put into for culture media. It is clear and it allows him good visualization of the tissue that has been removed. Fetal tissue is different in consistency than placental tissue.

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[113] Redirect Examination by Mr. Susman:

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[114] Q. You indicated those types of complications generally do not present themselves for some 72 to 96 hours, is that correct? A. That is correct.

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Q. (By Mr. Susman) Would it therefore make any difference with regard to infection whether or not the patient received the second trimester procedure prior to 18 weeks by method of D&E in a clinic or in a hospital? A. No.

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[117] **ALLEN S. PALMER,**

called as a witness, being duly sworn, testified:

Direct Examination by Mr. Susman:

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[128] Q. So the risk associated with prostaglandin is two or three fold that of D&E, is that correct? A. True.

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[130] Q. And generally what would be those charges? A. From one thousand to fifteen hundred dollars.

Q. Is that the hospital charge only, or does that include the physician's fee? A. That is the hospital charge.

Q. Exclusive of the physician's fee?

The Court: I didn't hear your answer.

The Witness: One thousand to fifteen hundred dollars.

The Court: You nodded your head.

The Witness: The hospital charge.

Q. (By Mr. Susman) Exclusive of the physician's fee? A. Yes.

Q. And do you know what the physician's fee is in those situations? A. I believe it to be $350, $400.

Q. Do you also have knowledge as to what the general charges are for outpatient D&E procedures under 18 weeks? A. Yes.

Q. And what are those, Doctor? A. Two hundred and fifty dollars to $350.00

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131] A. The statutory regulation of all second trimester abortions to be done in the hospital would be dangerous and unnecessary.

Q. In what manner is it dangerous? A. Inborn hospital infections are serious, and I believe placing a patient in a hospital for a second trimester abortion opens her to more dangers than the abortion itself does.

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[132] A. The safety of outpatient D&E procedures under 18 weeks is twice that of inhospital other procedures.

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[135] Q. The question, Doctor, is do you believe it would be in the best interest of your patient population to have a statute that would require or mandate parental involvement in each and every case of a woman under 18 desiring an abortion? A. No.

Q. Do you believe that such a requirement would place a burden upon the doctor-patient relationship? A. Yes.

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Q. Are your familiar with any hospital within the St. Louis metropolitan area that performs D&E second trimester procedures, Doctor? A. No.

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[136] Do you have any idea what that word means? A. The only understanding that I have is it means free. Other than that I have no understanding of the word.

Q. Free of what, Doctor? Are you talking in terms of slaves? A. In terms of slaves. Individual freedom.

Q. In this particular case when it refers not to slaves, but to women under the age of 18, do you have any idea what the concept means, free of what? A. I have no idea what the criteria could be set for that.

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[137] Q. In your practice, have you known women under the age of 18 who are capable of giving their informed consent? A. Yes.

Q. To the best of your memory, what is the youngest woman you can recall whom you felt was capable of giving an informed consent for an abortion? A. Fourteen.

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[149] Q. Doctor, approximately what percentage of your abortion patient population are under the age of 18? A. About 33 per cent.

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A. No. From my experience, we have had several cases where on spontaneous abortions we sent tissue to pathology. Most pathologists are not familiar with the pathology that we are interested in seeing or getting information from. You merely get statements like "products of conceptions," flat. There is a microscopic exam, and the gross pathology really is not satisfactory.

Q. What kind of exam do you make, if any, yourself, following an abortion? A. We make a macroscopic exam of all proportionate tissue.

Q. Do you feel that type of exam is satisfactory? A. I feel that I am an expert in screening my patients [150] in this situation and can delineate which patients should be — which tissue should be sent to a pathologist for evaluation under my direction.

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Q. Do you feel it should be the doctor's decision as to which tissue is forwarded for a pathology report? A. Absolutely.

Q. What are the charges for such a report in the area of St. Louis? A. We pay in our office $20.00 for a pathology report on one tissue specimen. If he makes more than one tissue specimen, each specimen is $20.00. You can divide a specimen up into as many tissue sections as you wish. If he has questions, the bill could be anywhere from $20.00 to $80.00.

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[151] A. Cost-benefit ratio is a judgment on the part of the physician as to whether the benefit of the test is significant to incur the cost of the test. The benefit to the patient of the test.

Q. Is that made in regard to each particular patient, or to the general population? A. That is the general population.

Q. Applying that rule of cost-benefit, do you believe that the cost-benefit theory would justify the sending of tissue from every abortion for a pathological exam? A. No.

Q. How many outpatient first trimester abortion facilities in the United States do you have some personal knowledge and familiarity with? A. Three.

[152] Q. Do any of those require pathology in each and every case? A. No.

Q. Do you feel that a statute which mandates pathology on all abortion tissue interferes with the doctor-patient relationship? A. Yes.

Q. Do you feel that it places a burden upon the delivery of abortion services? A. Yes.

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[184] **Redirect Examination by Mr. Susman:**

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[190] Q. (By Mr. Susman) Have you delivered premature children, Doctor, in your obstetrical practice? A. Yes, I have.

Q. Have you frequently delivered those children without the presence of a second physician? A. Yes, I have.

Q. Have you considered that to be sound medical practice? A. Yes.

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[199] **NAIM SAMUEL KASSAR,**

called as a witness, being duly sworn, testified:

Direct Examination by Mr. Susman:

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[209] A. The childbirth in every state is different. Like in Missouri it is 28. We don't have statistics, but around the nation it is anyplace between 20 to 40 per hundred thousand women die during childbirth. So to compare ten to 15, it is about one-fifth of the childbirth mortality.

Q. Do you feel that the performance of D&E procedures under 18 weeks is a procedure that can safely be performed in an outpatient facility? A. I think it is safer to be performed in an outpatient facility.

Q. Safer in an outpatient facility than what? A. Than a hospital facility.

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When you are in a hospital, you are more subjected to anesthesia, general anesthesia. Why, because the person — a lot of reasons. One, it has to be performed **[210]** in an operating room. And that in itself creates a lot of anxiety to being an operating room awake.

Q. A lot of anxiety to whom? A. To the patient. The patient, as soon as she enters the hospital, we have no control who is going to receive her. She might be received by somebody who does not believe in abortion at all and makes life miserable for her way before she reaches there.

Then in the operating room there will be people over whom I have no control who are going to be there. Some do believe in abortion, Some can't. And they will not be emotionally supportive.

So in my experience, we needed more anesthesia in the hospital than outside. And when you give anesthesia your chance of perforation —

Q. Let me stop you there. Tell us what the risks of anesthesia are. Are you talking about general or local? A. General anesthesia carries a certain mortality by itself, estimated to be according to our population one in 20,000. That is general anesthesia by itself.

Q. Totally issolated from the procedure to be done? A. Totally iolated.

Now, when you start to add a valium IV, demerol IV, a derivative of morphine, and added to it a local anesthetic, paracervical block, those combinations [211] tend to increase the risk by itself, knowing that anesthesia in the first trimester is the most common cause of death. Even local anesthesia.

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A. It is our belief the hospital is a good area which is disinfected, but we still see bacteria. It is more resistant to antibiotics. That is why I don't like to keep my patient in a hospital for a long time. Because the bacteria there are more resistant and infection is more [212] dangerous in a hospital setting.

Q. Do you have a personal experience of higher infection rate? A. In a hospital?

Q. Yes. A. I think I do for the simple reason, when you bleed more and the uterus is relaxed, you cannot evacuate the uterus good. You are subjecting yourself to higher risk of infection.

The Court: Doctor, when you say the hospital is the more dangerous place, more dangerous than any other place, what are you making a comparison with?

The Witness: In comparison to an outpatient hospital facility like a clinic.

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[213] A. The only danger — I don't know if you talk money as a danger, but for a lot of people it is an issue, and as soon as you enter an operating room your are charged $150.00 just because you are in the operating room. Then you will add gowns and things which are, you know, added. I think that is going to increase, you know — to give you a rate for a simple D&C in a hospital, you will be charged about a thousand dollars to have a D&C, not for an abortion. Just a simple D&C. So if you are going to do it for an abortion, I think it will run $1,500.00.

Q. Is that based on your experience at Truman? A. Yes, and in other hospitals I am working in.

Q. What other hospitals do you work in, Doctor? A. I work in Menorah, Shawnee Mission Hospital, Suburban Medical Center, Lakeside Hospital, Jackson County or Truman Medical Center, East, we call it.

Q. Do you believe the performance of D&E's under 18 weeks in an outpatient facility to be a safe and sound medical procedure? A. I believe so.

Q. Would there be in your opinion any additional scheduling problems because of bed availability or operating room availability by requiring it as an in-hospital procedure? **[214]** A. There is a lot of hassle about the time period. We will not be able to control the time we go into the operating room, because it can be taken by other cases. So, yes, it would be a difficult thing scheduling, according to how busy is the season in the hospital. And that goes by season.

Q. What effect, if any, do you believe an in-hospital requirement after 12 weeks has upon minors? A. Well, there would be no minor entering a hospital without parental consent.

Q. Is parental consent always available? A. No, not to my knowledge. It is most of the time available, but not always available.

Q. Would it have any other effect on minors? A. Other than you need to schedule them, and if you don't have the bed and surgery available that might delay them one week to two weeks, and sometimes it is impossible. If they are delayed beyond a certain time, then they will not be able to have an abortion.

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[216] Q. Do you believe that such a requirement, Doctor, places a burden upon the delivery and availability of abortion services? A. I think it would have a burden which is unneeded.

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First, the patient went out of the state and we **[217]** had less than, you know, we lost her. Second, the patient always comes late by the time they tell their parents. Third, some kids got kicked out of home and, you know, some came with bruised eyes after they told their parents, and they come late. And some they never told their parents and they run away. They run away and hide. I don't have anybody I know that run away, but when I look into the country, children run away from home, one of the reasons is they are scared to tell their parents.

Q. Is this something reflected in the literature? A. Yes, it is.

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[218] Q. Do you have any understanding of that term? A. Well, the first thing, it was difficult for me to understand, but even if I look in the dictionary, I don't know what meaning, how can you judge that the person is whatever, what is the criteria? They don't give us a criteria to go by to be able to tell.

If the person can calculate up to ten is it all right, or a person who could tell me a good joke, or what? I don't understand it.

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[223] Q. Have you ever delivered a premature baby? A. Yes.

Q. Have you done so without the presence of a second physician? A. Yes.

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[226] Q. Do you believe it places a burden upon the delivery and availability of abortion services? A. It does, because it requires a pediatrician to be present 24 hours there, and that is really uncalled for.

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[234] Q. Does this indicate to you at all what type of examination is to be conducted by the pathologist? A. Well, no.

Pathologists either do microscopic—like in our hospital, they only do macroscopic or they could do both, macroscopic and microscopic when it is needed.

Q. Do you perform an examination of the tissue you remove yourself? A. Yes.

[235] Q. What kind of exam? A. I do macroscopic examination.

Q. Macroscopic? A. My eyes.

Q. Do you send all of the tissue to pathology? A. The law requires us to, but I don't need it.

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When I look for two reasons. One, to make sure I got the pregnancy. Second, I have it complete. And this information, if I send it to the pathologist, they are going to come late and not going to help me. By the time they come back, I have already seen the complication of my procedure that she either is bleeding or infected. So for the two most important things in looking at the tissue, I am the one doing this.

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Q. Do you know what the cost of the pathology exam would be? A. If an honest pathologist do (*sic*) enough section on those to give a good report, it would need more than $30.00....

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[237] Q. Do you have an opinion as to whether or not this particular section interferes with the doctor-patient relationship? A. It does.

Q. Do you have an opinion as to whether or not this particular section interferes and places a burden on the availability and delivery of abortions services? A. I think it is going to add certain expenses on the abortion, and if you add them all together, it is going to be a burden on the people who cannot pay.

Q. Is the expense that would be added in your opinion justified on a cost-benefit ratio? A. Not at all. If we calculate we are having one million abortions a year in the United States, it is one million three hundred, but suppose it is one million, and we have to send all of these pathology specimens to a pathologist, this is $30 million expense we don't need. That is just if we do a one-slide specimen.

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[246] Cross Examination By Mr. Boicourt:

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[257] Q. Do you know of any other hospital in the State of Missouri which allows the use of dilatation and evacuation in the second trimester? A. Not to my knowledge.

Q. Doctor, I might be stating this somewhat simplistically, but does a D&E, a dilatation and evacuation abortion involve dismembering the fetus, including the crushing of the skull inside of the mother's womb, and then removing piece by piece the parts of the fetus which have been so dismembered? A. That is not the simple way. I think you are just **[258]** trying to, you know —

Q. That is the exact way it is done, is it not, Doctor? A. Well, dismembering, no, but taking it out. Your words are a little bit not exact. Yes, it is taken out. It doesn't matter as a whole or as a piece. It is sometimes taken as a whole if it is small, and sometimes taken by piece if it is big.

Q. In fact, during the second trimester, isn't it most often true that the skull is sufficiently large that it has to be crushed in order to be evacuated? A. Yes.

Q. What would you say is the chance of a fetus surviving in that type of operation, Doctor? A. Nil.

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[264] Q. Doctor, do you perform any abortions after 18 weeks? A. Yes.

Q. How late do you perform them? A. Twenty-two weeks.

Q. Do you perform any after 22 weeks? A. No, sir.

Q. Do you ever intend to perform any abortions after 22 weeks? A. No, sir.

Q. It is your testimony, I believe, that any abortion performed up to and including 22 weeks would not be on a viable child, is that correct? A. Up to 22 weeks? No, that is not what I say. I said I am not planning on doing it more than on 22 weeks, but the viability in my knowledge is up to — according to the last article I read from Glock and Hidias obstetrics is up to — the possible viability at the minimum is 26 weeks. Because before that the lungs will not be mature enough to —

Q. Then according to your own personal definition of viability, are you saying that you never perform an abortion or intend to perform an abortion on a viable child? [265] A. If you define abortion. I have to understand abortion. I have to know the nature of the pregnancy, because there is high blood pressure, diabetes, for the necessity of the health of the mother, on a viable — and that is way different than performing abortion on request for a woman.

Q. Doctor, I am having an awful hard time getting an answer from you. I will ask the question one more time.

Is it your testimony that you never have, you presently don't, and you never will use either D&E or a combination of prostaglandin and urea or saline to perform an abortion on any child which according to your definition is viable?

A. First, child is not — I am not familiar with your child. Child is after — according to the definition I know, it is between three to ten years old. Fetus is from embryo, eight weeks, to the day of delivery. So if you want to use any terminology, if you don't want to confuse me, use medical terminology.

Q. You are not confused, Doctor. You are arguing with me about my use of the word child.

Are you going to answer the question, or do you refuse?

A. I will not perform an abortion on a fetus, I am not performing after 22 weeks now.

[266] Q. And you do not intend to? A. I am not intending to.

Q. And according to your definition, any fetus aborted at 22 weeks is not viable? A. Yes, at 22 weeks is not viable.

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Q. Doctor, do you believe it is possible to — let's assume for a minute, a 26-week abortion. A. Yes.

Q. Do you believe it is possible for one physician to **[267]** both look after and care for all of the health needs of the mother during that procedure, and at the same time do everything necessary to save that infant?

Mr. Susman: I object to the form of the question unless it specifies which procedure is being used.

The Court: Will you add to it which procedure?

Q. (By Mr. Boicourt) Prostaglandin. A. Prostaglandin. Well, no, if I am knowing I am performing an abortion on 26 weeks, and I am intending — I never do that. But let me say theoretically it is needed for maternal health to deliver her at 26 weeks and I used the prostaglandin, I think I will need a pediatrician available, but I wouldn't use it.

Q. If, assuming that you were performing a hysterotomy or C-section at 26 weeks, do you believe it is possible for you to look after and care for all of the health interests of the mother while at the same time assisting the child or the fetus in surviving? A. It is called newborn, now. Yes, I believe I do need another doctor.

Q. Doctor, do you agree with me that medical science during the last ten years has made significant strides toward the preservation of more and more immature newborns? A. Yes, I would agree.

Q. Would you agree that in that same period of time, [268] perhaps since you graduated from medical school, that the minimum gram weight of which is considered that the fetus has a reasonable chance to survive has decreased considerably? A. The gram weight is a misleading thing, but yes. I will explain why it is misleading.

Q. I am sure you will have an opportunity to do that. But it has decreased? A. Yes, sir.

Q. Doctor, are you aware that there is presently research ongoing into the use of artificial wombs and fetal transplants? A. Artificial?

Q. Wombs? A. I am sorry. Womb being uterus?

Q. Yes. A. That they take the fetus from one and put it into another?

Q. Yes. A. That is not at 26 weeks. You mean earlier?

Q. Earlier, yes. A. You mean egg, when it is fertilized?

Q. Yes. A. Yes, I am familiar with it.

Q. I believe on direct examination you testified that at Mercy Hospital the magic weight was considered to be 1500 **[269]** grams, is that correct? A. Yes.

Q. Isn't it true that a fetus as small as 750 grams has a chance to survive? A. Yes, it does have a chance, 750, because if it is grossly retarded it is not the weight which counts. It is how mature is the fetus in age. Weight is misleading here, because in severe hypertension the fetus could be small but yet be at 30 weeks.

Q. Doctor, let us assume for a moment that you are performing an abortion at the 22nd week. A. Yes.

Q. Any kind of abortion, any type of abortion technique you care to use, on a woman, what would be your first concern? Her health or the fetus? A. I learned always in OB-GYN that the most important patient is the mother, and she is the main concern for me there because there is nothing else to concern. Twenty-two weeks, it is impossible to survive.

Q. You also stated your opinion on direct examination that anything less than 26 weeks is not viable, is that your opinion? A. Yes.

Q. Are you testifying that medical science knows of no instance where a child was delivered less than 26 weeks **[270]** and did survive? A. We have anecdotal incidents written in the textbook where a fetus was supposedly called eight months pregnant, and weighed in a grocery store it was 450 grams, but so far reviewing Parkland Memorial Hospital and large scale deliveries I have not seen less than 26 weeks surviving. There is a reason for it.

Q. Do you mean by the use of the word anecdotal, that it does happen but it is very unusual? A. No. Anecdotal means when you report something not accurately. That is what we call it in medicine. Anecdotal report. Because anytime you report in journals you have to say how did you measure it, how did you do it, what scale, what time, and you have to — so when you say I have done that, that is not enough. You have to document what you say. That is what we call anecdotal.

Q. Doctor, did you testify that at a study done at Mercy Hospital there is a survival rate, go-home survival rate of approximately 20 to 30 per cent of infants, newborns, born at 1,000 grams? A. Yes. Not studies. A review of mortality rate.

Q. Do you think a 20 to 30 per cent chance of natural life is insignificant, Doctor? A. I never said that. But a thousand grams, I am not talking about 500 grams.

[271] Q. What would be the chance of life for the newborn, if a D&E was used? A. I hope it would never be used.

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[280] Redirect Examination By Mr. Susman:

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[283] Q. Doctor, counsel inquired of you in regard to infections following abortion. When do infections first manifest themselves following abortion? What period of time following a procedure? A. The incubation period for infection has been always between 48 to 72 hours at the minimum.

Q. Would that be after the woman had left the out-patient facility? A. By two to three days.

Q. Would that be after the woman had left the hospital, if the procedure had been done in the hospital? A. Yes.

Q. In either case, she could then return to whatever **[284]** arena of her choice to be treated, is that correct? A. Yes.

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[288] ELIZABETH M. SMITH,

called as a witness, being duly sworn, testified:

Direct Examination By Mr. Susman:

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[294] Would you tell us if you can what the term emancipated means to you? How would you determine whether a 17 year old or younger female were, in fact, emancipated?

A. I wouldn't know how to determine that. I wouldn't know if living away from home but being supported by parents was emancipated or not. Or living at home but being self-supporting. It is confusing.

Q. Does the word emancipated carry any meaning to you? A. Not really.

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[296] A. I don't know if they are typical, but I do remember one case in which the mother was unwilling for her 15 year old daughter to obtain an abortion because she wanted to have the girl deliver and then allow the mother to raise the child as her own. This is a woman who very much wanted another child.

Q. By the woman, do you mean the mother? A. The mother of the patient.

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[306] Cross Examination By Mr. Davis:

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[312] Q. I believe you stated that in your opinion the minor herself is the best judge of whether her parents **[313]** should be notified or not before she consents to abortion? A. Yes.

Q. Is that true in all cases, Doctor? A. I don't know if it is true in all cases. Generally, I think that it is important to discuss with the young woman the possibility of obtaining parental consent. Many women do not object to this. I don't think it should be forced upon a woman.

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[322] Redirect Examination By Mr. Susman:

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[325] The Court: That stipulation is accepted.

Mr. Susman: Thank you.

At this time the plaintiffs would call to the stand Dr. Robert Crist.

[326] ROBERT D. CRIST,

called as a witness, being duly sworn, testified:

Direct Examination By Mr. Susman:

Q. Will you state your name, please? A. Robert D. Crist.

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[341] Q. Are you able to compare for us the risks to the patient **[342]** doing such a procedure, under 18 weeks by D&E in an outpatient facility, and the risks to the same patient, performing the same procedure, at the same stage of gestation, within the confines of a hospital? A. That approximate risk ratio is in the neighborhood of two. It is roughly twice as risky to perform it in a hospital by available statistics versus a free-standing clinic.

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There is a greater risk of giving a general anesthetic than to performing D&E's in the hands of a skilled operator in a free-standing clinic.

Q. Does general anesthesia carry with it risks of its own? A. Yes, considerable risks. More than performance of a D&E.

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[343] Q. Doctor, are you familiar with the prevalence of the use of the D&E method in the United States in 1973? A. It was unheard of as a D&E procedure. It certainly had been done by both accident and designed by operators prior to 1973. Myself included. But it had not been evaluated as a separate, distinct procedure.

Additionally, the use of laminaria to dilate the cervix had not been reintroduced into this country prior to 1973.

Q. Was it a prevalent procedure in 1973? A. Not at all.

Q. What methods were previously in use in 1973 for second trimester abortions? A. Second trimester was done nearly exclusively by hypertonic saline injection after 15, 16, 17 weeks when amniocentesis could be easily accomplished.

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[344] A. Our literature and our view of infections and our classification of infections in obstetrics and gynecology are divided into those acquired outside of the hospital and those called nosocomial infections, or those acquired within the hospital.

Any time you introduce a patient into the hospital environment you subject her to a strain of strains of bacteria to which she does not have exposure on the outside.

So the risk of in-hospital procedures is increased over those in a free-standing clinic.

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[346] I think in the Kansas City area you can anticipate an average cost with all ancillary services, drugs, et cetera, running nearly $200.00 a day. We add to that a hospital operating room fee, an anesthesiologist's fee and we have run a bill to a thousand dollars or more.

Q. Does that include the physician's fee? A. No, not the physician performing the procedure. That is the cost of the hospital and ancillary services.

[347] Q. Would you add to that please the physician's fee? A. That varies. The physicians performing a limited number of second trimester abortions in hospitals usually charge considerably more than the total fee for free-standing clinics. In the neighborhood of $350.00 to $500.00.

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A. Childbirth is at least ten times and perhaps as much as 20 times more risky, simply in terms of mortality, maternal [348] deaths statistics.

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Q. Doctor, do you have an opinion as to whether or not an in-hospital requirement such as we have been discussing interferes with the traditional doctor-patient relationship? A. Clearly, it does. If it makes access to medical services more difficult.

Q. Do you have an opinion as to whether or not it burdens the availability and delivery of abortion services? A. Very clearly, it makes it less acessible, more costly, more risky.

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[349] Q. ...Would you tell us what meaning the word emancipated conveys to you? A. No real meaning. I don't understand how it applies here. Emancipated at one point was considered a woman who was totally responsible for her financial wellbeing. A minor who was married. There is no definition of emancipated here.

Q. Do you feel if you were required to comply with this statute, would you be able to do so, or know how to do so? A. I wouldn't know how to use the emancipated portion of it.

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[351] A. Yes. By national statistics, statistics again drawing on the Communicable Disease Center, 50 per cent of the women age 12 and under who seek abortion services are pregnant by incest.

In those instances, I feel very strongly that the involvement of parents, one or both, is strongly contraindicated, and the mandation of parental involvement would jeopardize her well being.

There are many young women who have ceased to have a dialogue with their parents, and the involvement of those parents may subject or potentially subject that girl to physical violence by one or both parents.

Child abuse is not an uncommon thing, and one way that a crisis situation can be faced by parents who are abusers is to abuse that child. And the involvement of parents in those instances is contraindicated.

If the girl expresses a deep-felt fear of involving her parents because of fear of retribution through physical violence, I think it is contraindicated to notify or involve them in that situation.

[352] Q. Do you feel such a requirement would have any effect on the anxiety level of the patient? A. Well, clearly.

Q. In what manner? Raise it or lower it? A. It would increase her anxiety greatly.

Q. Can you tell us what connection there is between the anxiety level of a surgical patient and the morbidity and mortality following that procedure? A. Well, the greater her anxiety and changes in body metabolism, her ability to cooperate within the medical setting, those contribute to an increased risk of complications and problems.

Q. Do you feel that such a requirements as this would in any way affect the stage of pregnancy at which minors would seek an abortion? A. The younger the minor, as a general rule, the later she will be in her gestation when she seeks abortion services. The less available the abortion service, the longer she will wait. So it will tend to increase her risks rather than serve her health interest.

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[354] Q. Do you feel that there is any need for a second physician when such an abortion is performed by the method of D&E? [355] A. Absolutely not.

Q. Why is that, Doctor? A. There will be no chance of the fetus surviving.

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Q. Have you frequently delivered premature children without the attendance in the operating room of a second physician? A. Except in large university settings, that is the rule in this country.

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[356] Q. Are you telling us that there is a greater need for a second physician in term deliveries than there are in the cases of abortion by prostaglandin and saline? A. Certainly.

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[357] Q. Do you have an opinion as to whether or not this section impedes or interferes with the traditional patient-doctor relationship? A. By mandating a second physician's involvement, it certainly impedes.

Q. Do you have an opinion as to whether or not this section burdens the availability and deliverance of abortion services? A. It clearly limits it.

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[368] A. Forty-five per cent of my second trimesters are referred from the State of Missouri.

[369] Q. Perhaps you have already said this in other terms, but tell us why Missouri women come to you from great distances to get abortions at your facility in Kansas? A. They can't get second trimester abortions provided in Missouri. There is a hospital requirement. No hospitals allow abortion.

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[371] Q. ...Does this section give you any guidance, Doctor, as to the type of examination by the pathologist you should request when submitting the tissue? A. None.

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Q. Do you perform any type of examination on abortion tissue in each case? A. I look at the tissue in each case.

Q. Your perform a gross exam? A. That is correct.

Q. Tell us briefly how you accomplish that. A. Upon completion of the first trimester abortion, the material collected in a collection jar or bottle is poured onto a piece of gauze and grossly examined.

Q. What are you looking for, Doctor? A. I am looking for evidence that there might be molar degeneration or a hydatidiform mole. For evidence that there is sufficient tissue to coincide with my estimation of the stage of gestation, and if not, then that is a key for me to look further.

[372] Q. Do you routinely receive and send all tissue to a pathologist? A. Practically never.

Q. You do on some occasions? A. If I have serious question, I do, yes, sir.

A. At the University of Kansas, gross and microscopic exam costs $37.50.

Yesterday I called five hospitals in the metropolitan area which have an average cost of gross and microscopic, plus report, in excess of $40.00. So I would say at least $40.00 per examination, with both gross and microscopic.

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[373] Q. Do you belive that this section burdens the delivery and availability of abortion services? A. Yes, and unneccessarily increases the cost.

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[378] ROBERT M. KRETZSCHMAR:

called as a witness, being duly sworn, testified:

Direct Examination By Mr. Susman:

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[388] Q. How prevalent was the use of that method for second trimester abortions under 18 weeks in the United States in 1973? A. It was very limited, to my knowledge. Very few people had any experience with D&E.

Q. How prevalent is D&E today? A. Very prevalent. It is a common form of termination of a pregnancy.

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[389] Q. Are there significant costs increases to doing the same procedure in a hospital? A. Yes. If the patient is admitted to the hospital, very significant.

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Q. Doctor, do you believe such a requirement of telling a physician where he must do a post 12-week abortion **[390]** interferes with the traditional doctor-patient relationship? A. I think it does. I don't know of any other procedures where a physician is told where he can do an operative procedure.

Q. Do you believe it places a burden on the delivery and availability of abortion services? A. It certainly does, yes.

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Q. Can you tell us approximately what percent of your abortion population are women under the age of 18? A. About 65 per cent, thereabouts.

Q. Sixty-five per cent or under? A. Yes.

Q. Doctor, do you believe that it is in the best interest of that patient population under the age of 18 to be required to involve their parents in the abortion decision in every case? A. No.

Q. Would you tell us why, please? A. I think the information and papers that have been written on this show there is already a delay for the adolescent patient getting into the health care system. [391] And this delay is related to guilt feeling, culturally and morally described by our culture and the guilt feelings are related to also dealing with parents. Teenagers have great difficulty talking with parents about pregnancy.

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[392] Q. Would you believe this requirement interferes with the traditional doctor-patient relationship? A. Yes.

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[393] Q. Is there any reason to have a second physician present for a second trimester procedure on a viable child performed by D&E? A. No.

Q. There is no chance of survival of that fetus, is there? A. No.

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Q. Have you ever delivered premature children? A. Yes.

Q. Have you ever delivered premature children without the presence of a second physician? A. Yes.

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[394] Q. Would the presence of a second physician as required by this statute significantly increase the cost of the abortion procedure? A. Absolutely.

Q. Do you believe such a requirement is in the best health interest of the abortion patient population? A. No. I don't see how that patient would gain anything from that requirement.

Q. Do you believe that this section — or do you have an opinion whether or not this section interferes with the traditional doctor-patient relationship? A. I believe it does. It is more cumbersome to have two physicians present. I don't think the benefits to the patient, the person seeking the abortion, are existent.

Q. Do you believe it burdens the delivery and availability **[395]** of the abortion services? A. Yes.

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[399] Does this section give you any guidance as to the type of pathological exam you should request on tissue that you forward to the certified pathologist?

A. A tissue report — I don't know what that really means, whether they are talking about a microscopic evaluation or gross evaluation by the pathologist.

Q. Do you perform a gross evaluation on each abortion tissue? A. Yes.

[400] Q. Do you feel you are competent to perform a gross evaluation to the same degree that a pathologist could perform a gross evaluation? A. I believe I have seen as many of these samples as most pathologists, yes. I believe I can do it.

Q. Are you aware of what the cost of submitting each tissue from an abortion to a pathologist is? A. I think at Truman Medical Center our standard cost for a microscopic is around $25.00, miscroscopic evaluation. Around $15.00 for a gross evaluation.

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Q. Do you believe that this section interferes with the traditional doctor-patient relationship? A. I believe it is going to increase the cost, thereby interfering with the patient's relationship with me.

Q. Do you feel it will be a burden upon the delivery and availability of abortion services? A. Yes.

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[410] Cross Examination By Mr. Boicourt:

Q. Doctor Kretzschmar, my name is Mike Boicourt. I am an attorney for the defendants. I promise not to take very much of your time this morning.

Dr. Kretzschmar, what is the latest stage in pregnancy that you perform abortions at the present?

A. Twenty-two weeks.

Q. Is that also the latest stage of pregnancy in which you perform dilatation and evacuation pregnancies? A. No.

Q. What is the latest stage of pregnancy that you perform the dilatation and evacuation procedure? A. About 17 weeks is the best I can tell.

Q. Would you ever, or do you ever intend to use dilatation and evacuation procedure on a 26-week pregnancy? A. No.

Q. Do you think it would be good medical practice to use a dilatation and evacuation procedure on a pregnancy where you thought there was a likelihood or possibility the fetus was viable? **[411]** A. No, I don't think that is really in the concept of the law. Viability is an issue that I don't understand, but I have a pretty good — some grasp of it, and abortions are done prior to the age of viability. That is when I do abortions.

Q. Would you use a D&E procedure on a 26-week pregnancy? A. No, I wouldn't.

Q. Do you think it would be good medical practice? A. No, not at this time.

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[414] ROBERT D. CRIST

Cross Examination By Mr. Boicourt:

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[427] Q. Do you think it is good medical practice to use a dilatation and evacuation procedure on a 28-week pregnancy? A. Yes.

Q. You do think it is good medical practice? A. Yes.

Q. You think it would be better medical practice to use a D&E at 28 weeks than it would be to use prostaglandins or saline? **[428]** A. May I give you some examples from my practice in the last three weeks?

Q. If you will answer the question first, then I will let you give the examples. A. Yes, there are instances where it is absolutely the method of choice.

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[431] Q. Doctor, do you ever have any intention of trying to protect the fetus, if it can be saved? A. In an abortion patient?

Q. Yes. A. No.

Q. You believe then that the abortion patient has a right not only to rid her body of the growth, but to have a dead fetus?

Mr. Susman: Objection, Your Honor. His belief as to what her rights are are of no relevancy or materiality.

Mr. Boicourt: Certainly bears on his credibility.

The Court: No need to argue, gentlemen. He may answer.

Q. (By Mr. Boicourt) Do you understand the question? A. Would you repeat it, please.

Q. Yes. Do you believe that the abortion patient has a right not only to be rid of the growth, called a fetus in her body, but also has a right to a dead fetus? A. Yes, I do.

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[434] Q. Isn't it more often the case they are dismembered and removed in pieces, Doctor? A. That is correct.

Q. Isn't it more often true in a second trimester procedure that the skull would be crushed before removal? A. More often than not, that is correct.

Q. Doctor, would it be a true statement to say that the reason — if you will bear with me just a moment — would it be a fair statement and would you agree that the reason you find section 188.030 distasteful is because in your opinion no effort should ever be made to save a fetus where there is an abortion? A. I think there are exceptional circumstances where I would have to say no, I don't agree with that statement. There are circumstances where a woman has reached a point of viability where her well-being is in jeopardy, her life is in danger, she does not desire to continue the pregnancy or retain it. And in that instance, I guess we would call it an abortion, and the life of that fetus could be saved. I can see that as a potential.

Q. In any case, do you believe the first concern that you should have is always the health of the mother? A. Yes, I do.

[435] Q. And do you believe that as a general principle, as a general principle, where there is an abortion there should never be a live fetus? There should not be a live fetus, as a general principle? A. That is correct.

Mr. Boicourt: No further questions.

Redirect Examination By Mr. Susman:

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[436] A. One of the concerns — yes, I can. One of the concerns given for requiring pathology and tissue report is to identify ectopic or tubal pregnancy in abortion patients. If we may look for a minute at some statistics that I derived in a little investigation with Dr. Carl Tyler who is medical director of the reproductive division of the Communicable Disease Center in Atlanta, between 1972 and 1976 there were 3.8 million first trimester abortions done in the United States. During that time there were five deaths from ectopic pregnancies in patients who had had abortion procedures.

If we take the number that I used yesterday, roughly $40.00 for gross and microscopic examination, that means we would spend $30 million to detect each one of those ectopic pregnancies.

Now, carrying that a little further, when those cases were fully investigated by a medical doctor from CDC, three of the five died less than 72 hours after the abortion.

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[437] A. Three of those five ectopic pregnancy deaths occurred in less than 72 hours after the abortion procedure. Seventy-two hours is pretty quick time for a pathology laboratory to get a tissue report back to you, if they are doing a microscopic examination.

So, in other words, there were only two of those deaths that could have been detected and prevented. Two of those ectopic pregnancies and potential deaths could **[438]** have been detected and prevented by pathology.

Now, if we take two over a four or five year period of time within 3.8 million abortions performed, that raises the cost for saving one life to $76 million. That is a disproportionate cost-benefit ratio. No place else can we accept that kind of cost to benefit in medical practice.

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[440] Q. Doctor, in the delivery room, whose responsibility, which physician's responsibility is the premature child or the fetus born alive following abortion? A. The obstetrician until he voluntarily releases it to the care of someone else.

Q. It is not the responsibility of a pediatrician? A. Not unless it is the choice of the obstetrician to release the care of that infant to the pediatrician.

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[442] ENRIQUE VERA,

called as a witness, being duly sworn, testified:

Direct Examination By Mr. Susman:

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[444] Q. Doctor, would you tell us what meaning the word emancipated as used in (2), has for you?

For example, if the law were to provide that you could only treat in your practice of psychiatry without parental consent women under the age of 18 who were emancipated, can you tell us how you would determine or what standards you might use?

A. No, I cannot.

Q. Does it convey any meaning to you? **[445]** Q. It confuses me. I suppose I am familiar with the word as used in the general sense.

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[446] Q. Do you have any personal experience with situations in which the parents did become involved with a minor under the age of 18 who is seeking to terminate a pregnancy, and in which that involvement had adverse effects upon the minor? A. Yes, many times.

Q. In light of your answer of many times, would you give us some general characteristics of the types of adversities that resulted from those situations? A. Sometimes the parents because of their own concern about the social implication of the pregnancy might psychologically coerce the adolescent to have an abortion for which the adolescent is not emotionally ready or willing to have.

On the other hand, sometimes parents, because they experienced an illicit pregnancy out of a sense of failure of duty are involved by guilt and may need to postpone, ignore, or delay the decision that is in the best interest of the adolescent.

Q. Doctor, do you have an opinion as to whether or not a requirement that would mandate parental involvement for minors under the age of 18 seeking an abortion, interferes with the traditional doctor-patient relationship? A. Yes. It would not allow the doctor and the patient to do what is most sensible and practical at the moment to best **[447]** help the patient.

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[463] J. CHANDLER SMITH,

called as a witness, being duly sworn, testified:

Direct Examination By Mr. Susman:

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[466] Q. Would you tell the Court, please, whether or not the type of examination to be conducted by the pathologist is indicated to you in the wording of the section? A. No, I don't see that here.

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[467] Q. Do you have an opinion, Doctor, as to whether or not a physician who performs abortions can conduct a gross examination of the abortion tissue as well as yourself or any other certified pathologist? A. I believe that is correct.

Q. Doctor, in how many cases, approximately, can you give us any data as to how often molar tissue will occur and can be identified in abortion tissue? A. Well, that is estimated to occur approximately once in every two thousand pregnancies.

Q. Can you give us a percentage or figure as to how often you believe that the recognition of molar tissue would be picked up by the attending performing physician who renders the abortion? A. I think it would be difficult for him to miss **[468]** identifying molar tissue. It is that conspicuous.

Q. Can you tell us, Doctor, how often one would suspect, or pick up the possibility of an ectopic pregnancy from the viewing of first trimester abortion tissue? A. Findings compatible with ectopic pregnancy might be expected on the order of once in every 250 to 300 specimens.

Q. And would the same high percentage be expected as to the performing physician making that same diagnosis by his examination of the abortion tissue? A. Yes. I think he would recognize it in that same frequency.

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[471] GRACE KETTERMAN,

called as a witness, being duly sworn, testified:

Direct Examination By Mr. Davis:

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[482] A. Very many times when this is not a planned pregnancy denial is used. In fact, I have seen it used to the point that young women have gone into labor, a full-term pregnancy going into labor, and never having admitted to themselves or anyone else that they were pregnant.

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[491] Cross Examination By Mr. Susman:

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[494] You indicated that your understanding, and correct me if I misstate your remarks, but my notes would indicate you testified that your understanding of the term [495] emancipated was when one of several possibilities; one, was when the child was verbally or physically excluded from the parental home.

A. Yes.

Q. And, secondly, when a determination by a judgment of the applicable juvenile court was made that in fact this particular minor is emancipated? A. Yes.

Q. And as I recall, those were the two definitions that you gave to the term, is that accurate? A. That is correct.

Q. It is your opinion then, Doctor, is it fair to say, that if a minor were to leave home of her own accord, she would not then necessarily be emancipated? A. That is correct.

Q. And that would be true even if she were living in her own apartment and supporting herself through some job, correct? A. Correct.

Q. And that would also be true if she were under the age of 18, and perhaps attending her freshman year of college away from home, correct? A. Not necessarily. If she is away by the consent of her parents, and is able to function on her own, and, in fact, by the age of 17 I am aware legal action is rarely taken by [496] juvenile courts. I am talking about the actual legal minor, who is under the age of 18. Probably under the age of 17.

Q. Let's talk about the ones under 18, because that is what the statute talks about, does it not? A. Yes.

Q. So the juvenile court proceedings would really not be applicable to those that are 17. A. I am sorry for the fuzziness of the age at that point. I am concerned with the truly minor child, who is not capable of managing her own life.

Q. If we may, let's direct our concern to that entire class of minors under the age of 18 in the same fashion as the statute does.

Would you think that a child would be emancipated, Doctor, and let's assume the age 17 where she is gainfully employed, entirely supports herself, but still happens to reside in her parents' home and pays them room and board?

A. I am sorry, I am not clear what your question is.

Q. Did you understand the example? A. Yes.

Q. The question is, would you consider that 17 year old fully supported child to be emancipated because she still resides in her parents' home. A. Probably not.

Q. Are you sure? [497] A. It would depend on the case.

Q. Does the statute give you any guidance? What additional facts would you like, Doctor? A. I would like to know whether she is emotionally and mentally in need of supervision and guidance by her parents. The very fact of her residing at home would tend to implicate the fact that she may need some help in deciding many issues.

Q. So it is your testimony that her degree of dependency for emotional guidance by her parents is a factor to be utilized in the determination of emancipation? A. I would like to see that happen, yes.

Q. Is that your understanding of the word, Doctor? A. That is not my understanding of the word.

Q. So you do not believe that the dependence upon the parents for emotional guidance is a factor of emancipation? A. I apologize, I lost you there.

Q. Let me ask it again. Do you believe the quality of how much dependence a 17 year old child has for emotional guidance from her parents is a factor of whether or not she is emancipated for the purposes and the way the word is used in this section under consideration? A. May I answer that by rephrasing what I think I hear you say?

Q. Certainly. [498] A. I believe that a young woman who is in any way still in need of guidance and advice and help from her parents under the legal age of 18 is not truly an emancipated minor.

Q. For the purposes of this section? A. Right.

Q. How do you make that determination, Doctor? A. By information. I would have to know the young person, know the family, know what the relationship is, know what her capabilities are in terms of making wise decisions, and not emotional ones.

Q. Is it not a fact, Doctor, that many women, 18, 19 and even older, for various aspects of their life may still have some dependence, request assistance from their parents? A. One would hope so, yes.

Q. Then they would not be emancipated either, is that correct? A. Perhaps we never are totally emancipated.

Q. And I assume whenever you use the word emancipated, you are using it in the context the meaning conveys to you from this statute, correct? A. I understand it in this concept to be a legal term.

Q. And I am trying to understand how you understand it, and how you define it, and what it means to you. A. Emancipation means to me —

Q. As used in the statute. [499] A. As used in the statute, someone who is capable and fully by her living style shows she is able to manage her life apart from her family who does not need seriously the input of that family, or who has shown legally the ability to survive without them.

Q. Are you now removing the earlier requirement that you place in this term that she has left with their consent or has been forced out? A. That is a legal term. I do not believe that many such young women who have been forced out are emotionally ready for emancipation, but I know they are legally considered to be so.

Q. Again, if you will, please define your definition of this term as the meaning you attributed to it as it appears in this statute. A. I have to leave that to legal minds, sir.

Q. Are you unable then to tell us the criteria of emancipation that this word conveys to you as contained in this statute? A. I can tell you for myself what creates an emancipated person, but I cannot tell you what the legal definition is.

Q. Is it a fair statement that you do not have a clear concept of emancipation as used in this statute and as to what it means as used in this statute? A. I have a clear concept as I have already testified, sir, [500] and I have clarified that legally in my best understanding of legal terms. To apply to people who are excluded by judicial hearing or by family decision apart from the family.

Q. Doctor, I want you to leave aside, if possible, any past understanding of emancipation for any other legal purposes, and to which it has come into play in your practice, which I am sure there are many for other purposes.

We are only discussing the term as used in this section and what meaning, if any, it conveys to you for the purposes of this secton and for no other legal purpose whatsoever.

Now, with that understanding — do we have that understanding? A. I don't think so.

Q. Can we have that understanding? A. I wish I were clear on what you want.

Q. If you can, I want you to tell us the criteria and the definition of the word emancipated as used in this section, and what it means to you, and what standards would be applied by you to determine, or what guidance this word gives to you as to what is meant. Not in any other context, just as used in this section.

Mr. Davis: Your Honor, I object to the question. The statute speaks for itself. Whether there is any guidance in the statute I don't believe Dr. Ketterman can **[501]** testify.

The Court: Overruled.

Q. (By Mr. Susman) Are you able to do that, Doctor? Yes or no? A. I think — let me say no, because I am really lost —

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[505] Q. Is it your understanding that (c) would allow the court to find that it is not in the best interest of the minor, even though she may be capable of making her own decisions? A. Yes.

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[511] Q. You also indicated that parents generally want the best. May I assume from that statement that there are cases in which parents do not want what is best? A. There are some situations in which parents have become so estranged from the child that they want nothing further to do with that child and don't care whether it is good or bad.

Q. And in those cases parental involvement would not be in the best interest of the child, would it, Doctor? A. That is correct.

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[513] Q. And do you feel that this law as written, not as you might like to see it modified, places a burden upon the delivery and availability of abortion services? A. Yes, it does.

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[603] BERNARD N. NATHANSON,

called as a witness, being duly sworn, testified:

Direct Examination By Mr. Davis:

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[608] Q. Thank you, Doctor. Will you refer to Section 188.025? A. Yes.

Q. That section requires abortions after the first 12 weeks of pregnancy to be performed in a hospital, does it not? A. Yes, it does.

Q. Doctor, do you have an opinion as to whether this is a reasonable regulation? A. Yes, I do.

Q. What is that opinion? [609] A. I think it is a reasonable regulation.

Q. What do you base that opinion on? A. The morbidity rate for abortion after the twelfth week rises significantly, and some of the adverse developments, or adverse events surrounding abortions after the twelfth week can be in certain instances catastrophic.

These abortions, therefore, are more safely performed within the walls of an institution such as a hospital.

Q. Do you have an opinion as to whether a dilatation and evacuation procedure performed at 18 weeks, between 12 and 18 weeks, could be safely performed in a free-standing clinic? A. Yes, I do.

Q. What is that opinion, Doctor? A. My opinion is that particular operation should not be performed outside the walls of a hospital.

Q. Why is that? A. Because, as I indicated to you in answer to an earlier question, this particular procedure at that time in pregnancy is a procedure which carries with it certain serious risks and hazards, some of which can supervene with astonishing swiftness, and would require emergency treatment. And it is my feeling, my opinion, that therefore these procedures should be carried out in a hospital.

Q. Doctor, would that be your opinion with regard to [610] second trimester abortions performed with prostaglandins? A. Yes.

Q. Would that be your opinion also for abortions performed with saline? A. Yes.

The Court: For the same reasons?

The Witness: For the same reasons, yes.

Q. (By Mr. Davis) Doctor, do you have any second trimester abortion technique which in your opinion could safely be performed outside of a hospital? A. No, I do not.

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[615] Q. Would you tell us, Doctor, which of those methods could result in a live birth? A. Yes. Abdominal hysterotomy would in all instances result in a live birth. The prostaglandin instillation method would result in a substantial number of cases in a live birth. The saline technique rarely in a live birth, and the D&C or D&E, never.

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[622] Q. Doctor, let me go on to Section 188.047. [623] Have you read this section? A. Yes, I have. It refers to pathologist's report, does it not? A. Yes, it does.

Q. Do you have an opinion, Doctor, as to whether it is reasonable and medically necessary to require a pathology report on the products of each abortion? A. Yes, I do.

Q. What is that opinion, Doctor? A. My opinion is that it is absolutely necessary to obtain a pathologost's report on each and every specimen of tissue removed from abortion or for that matter from any other surgical procedure which involves the removal of tissue from the human body..

Q. Doctor, at the New York Center for Reproductive Health, is that— A. The Center for Reproductive and Sexual Health, or you may call it "Crash," if you like.

Q. At you clinic, Doctor, in New York, did you require a pathologist's report? A. Yes, we did.

Q. In each case? A. In each case.

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[629] Cross Examination by Mr. Susman:

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[631] Q. I did qualify it by saying from 13 to 15 weeks. A. Yes. Between 13 and 15 weeks, I would agree, yes.

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[634] Q. What was the prevalence of the D&E procedure in 1973, Doctor? A. It was exceedingly rare. If you are referring to abortion done after the 12th week of pregnancy by D&C.

Q. D&E. A. D&E is an evasive term. It is D&C done after the 12th week, and that was in 1973 rare or very infrequent.

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[641] A. The rates for morbidity outside of a hospital are probably no different than the rates in-hospital.

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[642] Q. (By Mr. Susman) Do you support a statute that would require parental involvement or notification in all cases without exception, and would not allow the alternative in those cases which might justify for the physician to merely get the consent of the court without parental involvement? A. No. I indicated to you, I can conceive of very isolated specific instances where it would not be mandatory **[643]** to involve the parents in the decision or the consent, but that such a statute would have to spell out very clearly in my mind those very special circumstance.

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[644] Q. Is there a possibility this might have some adverse health interest upon the minor, if they ultimately get the abortion that had been delayed two weeks because of this procedure? A. There is a possibility of anything, but a reasonable probability would be that, yes, there is an increasing morbidity as time goes by, as we indicated earlier, with respect to the performance of abortion.

Q. Would you favor or support a statute that had an exception to that in cases where it might throw the minor into the second trimester? A. I would favor such a statute if it were confined to those women who had accompanying serious health problems, which would then make the second trimester abortion significantly more morbid and significantly more hazardous than it ordinarily would be.

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[647] A. My answer is that a woman who has borne a child is with reasonable probability in my understanding an emancipated minor, regardless of her present circumstances.

Q. Would that also include a divorced woman now back living with her parents and depending on them for support? A. Probably.

Q. So as I understand it then, the fact of either a marriage or prior birth basically is determinant of whether or not a minor is emancipated or not, is that correct? A. Yes, in my understanding.

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[746] PIERRE KEITGES

called as a witness, being duly sworn, testified:

Direct Examination By Mr. Davis:

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[748] Q. Doctor, have you had an oppportunity to read Section 188.047? A. Yes.

Q. Of the statute under consideration here? A. Yes.

Q. That statute provides for pathology exams, does it not, Doctor, I think in every case of abortion? A. Yes.

Q. Do you have an opinion as to whether it is good practice, good medical practice, to require a pathology exam in every case of abortion? A. Yes, I think that is an important point. To me that feature has nothing to do, as far as I am concerned, with abortion. It is just good sound medical practice. It has to do with all of medicine.

Q. Doctor, are you aware of any other surgical procedure in which pathology exams are not routinely conducted? A. Yes. I think one would find in certain hospitals on the basis of the recommendation of the staff, and I would **[749]** hope approved by the administration and board, of those hospitals, that certain tissue are categorized as not requiring microscopic examination.

These are referred to sometimes as a gross only situation. These might include tonsils, hernia, maybe a hemorrhoid. I personnally am opposed to that, because at least once a year we find unsuspected malignancy in a tonsil, or hernia, or hemorroid. But this is in their professional judgment appropriate and I am sure one could find hospitals where that is the case.

Q. Doctor, in your professional judgment, is it ever appropriate not to conduct a pathology exam on the products of a surgical procedure? A. No. For two reasons. I think we live in a litigious society, and medical-legal documentation is absolutely paramount. The biggest problem the medical profession has is poor records. And, second, I think it is outstanding medical care because in those occasional cases, one finds a serious disease at a time when it is ideal to literally cure the patient. In other words, you are finding a disease before it is asymptomatic. You find it through serendipity to another procedure.

Q. Doctor, do you have an estimate as to whether that would be a large number of cases? A. No, it would admittedly not be a common occurrence. **[750]** Like I said, last year I found an unsuspected malignancy in a tonsil. A couple of weeks ago we found an unsuspected malignancy in a hernia sac. I had a D&C specimen in a threatened abortion last year that had unsuspected tuberculosis in it.

Q. I take it then, Doctor, that it would be a small number of cases in all similar surgical procedures where a benign product is removed through elective surgery, is that correct? A. That is correct. To me a point that is overlooked is this business of percentages. It doensn't mean a thing when it is you. I don't care if something happens once in a hundred thousand, when it happens to you, it is one hundred percent. I don't know of any patient that has ever felt better getting bad news because you say this rarely happens.

Q. Doctor, what kinds of examinations in your opinion should be performed on products of abortion? A. Well, some are obvious. You can see a fetus or embryo, anyone could tell grossly that was a pregnancy. In those cases, I would think just for the documentation purposes one would want to send that tissue to the laboratory and document that. If this happened to me, I would proceed no further. I would simply look at it grossly, it is obviously a pregnancy, and report it and document it as such. The difference is I wouldn't just be saying that, I would be putting [751] down an official diagnosis and putting my name on it, which would make me professionally liable for the accuracy of that interpretation.

Then if there was a question, or one couldn't tell, which in a significant number of these specimens you can't tell by looking at them, these, one would want to subject to microscopic examination. And here, if it was a small specimen, we would put it all in and look at it. Some of these specimens you can get it all on one glass slide, so it is no major task, and then in other cases, you might have 40 or 50 grams of tissue, so you would selectively choose areas to examine microscopically.

And in that situation, we have sometimes what we call re-cut. I have done that and found something that looked suspicious, but it was not obviously pregnancy, and then I would go back and put it all in the next day, and in that situation occasionally one does find it.

Q. Doctor, do you have an estimate as to how expensive, what the costs would be for these examinations? A. I think there is a tremendous obligation to keep the cost of something like this down, because anytime you ask, and this is irrespective of abortion, but when we in our hospital, for example, it is sent by the surgeon, we want everything that is taken out, whether it is a foreign body or what, sent to pathology. You are opening yourself wide open [752] to generate funds for the hospital, to be candid, and so we are extremely careful to hold the cost at a minimum. Our gross only charge is $10.00. I think you would find the range—I have not done a study, so stand corrected—would be between $10.00 and $35.00 for, varying from a gross only, and on up and including microscopic. On that basis due to the usual significant costs of the procedure, that our staff felt this was not an inordinate charge as long as we monitored it carefully.

Another privilege we give the surgeon, he can request gross only. If it is obvious to him in the operating room, he can tell the nurse to put gross only and if we agree with him, that is what we will do.

Q. And if you disagree with him? A. Then we are permitted to proceed and do a microscopic examination to verify the impression.

Q. The range of cost—to make sure I am clear—the range of cost for gross or any number of microscopic examinations would run from $10.00 to $35.00 for a procedure, is that right? A. I think for the usual. Now, you can go out here this afternoon and find a hospital that is higher than $35.00, but my feeling would be that the range would be from $10.00 to $35.00.

Q. In your experience, Doctor, as a pathologist, where [753] numerous tissue samples are received from a particular source and you anticipate that that will continue to be the practice, is it common to arrange for a fee schedule which will minimize the cost to the source of those tissue samples? A. Yes. This has happened because of the popularity of surgery centers and day surgeries. We have days when we do nothing but tonsils and adenoids in one section of the hospital. Other days where two or three rooms and the outpatient area is occupied by dermatologists and plastic surgeons removing skin biopsies. So to hold the cost down, we could sit down with these groups and say since this is a large batch procedure, we don't want to circumvent the principle of examining all of the tissue, but we do these for a flat understood rate out of deference to the patients.

Another feature we have plugged in, any time there is not going to be a patient or hospital charge, in our case with the helicopter, we would get a number of indigent patients. A nun will come down and tap on the window and say, "This patient has no money." And we won't charge. So we will not charge a patient if they can't pay.

So what I am saying is the system of charges has to be what gives. We must never fracture the principle of examining everything to document the human tissue.

Q. Doctor, in your opinion, could any physician perform a gross examination of abortion tissue as well as you could? [754] A. In certain cases. If you see an embryo that has eyes and hands, you don't need to be a physician. But in many cases, not even I can tell. So you could have to qualify that. Each case is different. And this is where the gross only come in. If it is obviously a pregnancy, a gross only would be permissible, because the obstetrician can see chorionic villi, you can see them, everyone can see them. In other cases, it is questionable, and you must do a microscopic to prove that chorionic villi are there.

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Cross Examination By Mr. Susman:

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[755] Q. (By Mr. Susman) Directing your attention, Doctor, to the same section, 188.047, in your understanding of that section, does it give any guidance as to what types of exam must be conducted by the pathologist, whether it is to be a gross or microscopic? A. No. I see no specific instructions as to gross, microscopic, either or both.

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[758] Q. And would it be correct to say the criteria of which tests are given to which patient are done on what is commonly known as a cost-benefit ratio? A. True. . . .

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[759] Q. What about physicians working in their offices, or outside of hospital settings, do they not traditionally make the determination of whether or not tissue they may remove is forwarded to a pathology lab? A. yes.

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[762] A. Thirty-five dollars. I think in one of the hospitals it is $37.50, but I have to admit my ignorance on tht point.

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[765] **DR. RICHARD SCHMIDT,**

called as a witness, being duly sworn, testified:

Direct Examination by Mr. Boicourt:

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[776] Q. Doctor, may I now refer you to Section 188.025 of the challenged Missouri law. A. Yes.

Q. Doctor, in your best professional and medical opinion, does it constitute good medical practice to perform all post first trimester abortions in a hospital? **[777]** A. Without any question.

Q. On what do you base that opinion, sir? A. Well, on the rising mortality and morbidity related to gestational age. In every study that I have seen, both morbidity and mortality increase as gestational age increases, and this is a straight-line relationship.

The reason for drawing a line at 12 weeks obviously it is not necessarily a hard and fast line, but we use that same designation in many other medical situations. How one handles, for example, a missed abortion. The factors involved are not only the size of the uterus and the size of the fetus over 12 weeks, but also the development of the placenta and its attachment to the uterus.

In that area, beyond 12 weeks, you began to get a very well developed placenta, firmly attached to the wall of the uterus and therefore when it separates it is capable of producing substantially greater amounts of bleeding.

The character of the uterus itself, when the uterus is relatively small, the wall is thicker, firmer, contracts more readily. As it gets bigger, it is thinner, much more subject to perforation, to rupture. Everywhere you look, the potential for complications increases substantially.

Q. Doctor, is the position of the American College of Obstetricians and Gynecologists as pronounced in its standards [778] and their statements of policy in accord with the view you just stated? A. Exactly. I believe if you recall that was very specifically stated in the standards that I read.

Q. Doctor, would your opinion change if we were speaking about an abortion performed by a dilatation and evacuation method between 13 and 18 weeks of pregnancy? A. Would my opinion change?

Q. Yes. Not at all. Not at all. I recognize that that is purported to be an acceptable procedure. But I do not agree with that.

Q. Are you familiar with statistics published by the Center for Disease Control? A. Yes, sir.

Q. Do you know of any of those statistics which relate to the increased risk for D&E procedures during the second trimester? A. Yes, indeed. They go up directly proportional to the gestational age, and they take a big jump beyond 12 weeks.

Q. Doctor, in your experience, what additional safeguards, if any, are provided in a hospital as opposed to a free-standing outpatient clinic? A. Oh, gee, they are almost too numerous to mention. Probably the biggest single thing is life-saving equipment, [779] personnel and materials. A blood bank. Expert anesthesiologists. An intensive care unit. You know, it is just almost impossible to enumerate all of the things we take for granted in everyday medical procedures that are very difficult to duplicate on an outpatient basis.

If you notice in the standards of the College, one of the points made was to preserve the basic safeguards as provided in the hospital.

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[802] Cross Examination by Mr. Susman:

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[806] Q. Are you aware that there is widespread practice, and again without saying whether it is a majority or not, of outpatient abortion facilities in the United States of not referring pathology in all cases of first trimester, but doing it on a selective basis? A. Yes, I certainly am.

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[808] Q. Without having at hand exact numbers or percentages, Doctor, is it a fair statement to say that it was not a common method of second trimester procedures in 1973 in this country? A. That is certainly correct.

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[813] Q. The choice of where a procedure is to be performed is traditionally the doctor's responsibility and decision, is it not, along with his patient? A. Along with his patient, yes. I will say, however, Mr. Susman, that like the vast bulk of what physicians do, it is determined by a highly-refined not just tradition, but based on a body of scientific evidence and experience, and most of the things we do in medicine are in effect regulated in that way.

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[817] A. Any procedure, yes, indeed. But I assume the point you are making is, is that acceptable? It is acceptable if it works all right, yes.

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[832] Q. Do you see any exception in this statute for such a circumstance, Doctor? A. No, I don't.

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[836] Q. . . .Is there any reason that you can give us for the attendance of a second physician for an abortion on a viable fetus by method of D&E. A. No.

Q. There is no possibility of survival, is there? A. No. . . .

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[845] Does this section in any way specify what type of examination, whether it be gross or miscroscopic to be performed by the certified pathologist? A. No, sir.

Q. Gives no guidance? A. Says nothing related to gross or microscopic.

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[846] In a practical sense, with elective abortion, obviously one of the very significant points involved is, number one, is this woman pregnant; and, number two, is there actually fetal tissue there.

If he can identify fetal tissue, that part of the necessity may very well be accomplished with a gross examination. . . .

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[871] DR. MYRE SIM,

called as a witness, being duly sworn, testified:

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[903] Cross Examination by Mr. Susman:

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[910] A. Yes, I would like to think that if this is included in the regulation, that this emancipation is a legal term and there has been some due process of law, which has emancipated the minor, and if there has been such, there would be a record of it.

One would like to see the record of this emancipation to at least know whether the minor is emancipated in this sense or not.

Q. So you are telling us it is your opinion of the meaning of this term as contained in this section depends on whether or [911] not there has been a prior legal proceeding in which the minor has been officially adjudicated to be emancipated? A. This is how I would read it, sir.

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[912] Q. Doctor, you are aware, are you not, that if the doctor does not comply with this statute he is subject to jail and fine, or both? That this is a criminal law? A. I would have thought that if the doctor had a very good reason for ignoring the statute, he would be able to defend himself against these charges successfully.

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[915] Q. Is it not true that a certain significant percentage of patients with an imposed delay of fourteen days would pass from the first trimester into the second trimester? A. Yes, sir.

Q. Would that be in their best health interest, Doctor, assuming they are ultimately going to have an abortion? A. Not in that particular group, no.

Q. Does the statute in your understanding make any exception for that? A. I have not seen any.

Q. Would you agree with me that because of the failing of any exception to appear that under those conditions would [916] impose a burden upon the delivery and availability of abortion services?

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[922] Q. In your experience, and don't you believe that many parents would fail to support a minor's decision to abort? A. Very many do, yes.

Q. Many parents might fail to support a minor's decision to carry to term, as well, correct? A. Yes. Many parents talk their child into an abortion, who may not wish to have an abortion, yes.

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TRANSCRIPT OF TRIAL ON REMAND
(August 6, 1981)

[5] JUDITH A. WIDDICOMBE,

called as a witness, being duly sworn, testified:

Direct Examination By Mr. Susman:

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[7] Q. Did the corporation commence to offer second trimester procedures immediately or shortly after the original opinion by the Court in this cause? [8] A. Yes, approximately two and a half weeks later.

Q. During that year and a half period to date, would you tell us, please, how many first trimester procedures have been performed? A. 11,190.

Q. During that same period that the 11,190 first trimester procedures were performed, how many second trimester procedures were performed? A. 1,160.

Q. All of these procedures have been performed at the premises and at the facility of Reproductive Health Services, have they not? A. Yes.

Q. Reproductive Health Services has only one facility? A. Yes.

Q. That is located at 100 North Euclid in the city of St. Louis, Missouri, correct? A. Yes.

Q. You also maintain, do you not, complicaton rates? A. Yes.

Q. Would you tell us the total number of complications during this same 18-month period for the first trimester procedures? A. There were total complications of 146.

Q. Will you tell us, please, for the same 18-month period [9] the total number of complications for second trimester procedures? A. 12.

Q. It is a fact, is it not, that on occasion, complications necessitate the hospitalization of a patient? A. Yes.

Q. And have you maintained statistics as to the total number of patients hospitalized as a result of complications following an abortion procedure? A. Yes.

Q. Would you tell the Court, please, the total number of patients hospitalized as a result of a complication incurred by reason of a first trimester abortion procedure performed by Reproductive Health Services? A. Of the 146 complications, 37 were hospitalized at some point.

Q. And for second trimester procedures? A. Two.

Q. That would be 2 out of 12? A. Correct.

Q. The figures you have given us so far are basically raw figures, are they not? A. That is right.

Q. You also keep them by percentages so there can be a comparative value between the first and second? [10] A. That is right.

Q. Would you tell us, please, the percentage rate of complications for all first trimester abortion patients? A. 1.3 percent.

Q. 1.3 percent. That basically would be 13 per thousand patients, correct? A. Yes.

Q. For the first trimester? A. Yes.

Q. Would you give us, please, the same comparable rate for the second trimester abortion patients? A. 1.03.

Q. And that would be equivalent to ten per thousand, would it not? A. Yes.

Q. Do you also keep rates —

The Court: I didn't hear you.

The Witness: Yes.

Q. Have you my request compared those two percentages, percentages of complications between first and second? A. Of the hospitalized?

Q. No, only of complications at the moment. A. Yes.

Q. Which procedure, the first trimesters or the second trimesters, have the highest complication rate? [11] A. The first trimesters.

Q. And how much higher were they than the second trimester rates, by percentages? A. 26.21 percent.

Q. Have you also computed the percent of procedures — percent hospitalized by first and second trimesters? A. Yes.

Q. Of the total first trimester procedures, what percent of the patients were hospitalized? A. 94.12. I am sorry, restate the question.

Q. The total number of procedures, first trimester procedures. A. Hospitalized?

Q. How many of the first trimester patients were hospitalized of all procedures done? A. 37. By percentage, .33.

Q. So .33 percent of all patients who received first trimester abortions were hospitalized? A. Yes.

Q. By reason of complications? A. Yes.

Q. What percentage of all the patients who received second trimester abortions were hospitalized? A. .17 percent.

Q. Was a greater percentage of patients first trimester or [12] second trimester hospitalized? A. First.

Q. How much higher was the percentage? A. 26.21 percent.

Q. In regard to — A. Percentage rates?

Q. Of hospitalizations? A. Of hospitalizations were 94.12.

Q. So 94.12, a greater percentage of that amount of first trimester patients were hospitalized than seconds? A. That is right.

Q. Do you also maintain statistics on the percent of actual complications that are hospitalized as opposed to first and second? A. Yes.

Q. Was a greater percent of complications in the first trimester or the second trimester hospitalized? A. First trimester.

Q. And how much higher was that percentage? A. 52 percent.

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[19] Cross Examination By Mr. Boicourt:

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Q. I understood you to testify that during the approximately 18 months that Reproductive Health Services has been performing second trimester abortions, your facility has performed some 1,160 procedures? A. That is correct.

Q. All I take it by the method of dilatation and evacuation? A. That is correct.

Q. All between 14 and 19 weeks? A. Yes.

Q. That is 14 to 19 weeks from the last menstrual period? A. Beginning of the 14th week, which would be at the 2.4 ultrasound reading, 2.3 being the cutoff for the first trimester by last menstrual period.

The Court: Mr. Boicourt, I think the original testimony was 14 through 19.

[20] Mr. Boicourt: That is what I intended to say, Your Honor.

Q. (By Mr. Boicourt) These, again, when you compiled this information that they were performed between 14 and 19 weeks, that was from 19 through 19 weeks from the last menstrual period, is that correct? A. That is correct.

Q. And not from the date of conception? A. That is correct.

Q. Which would be two weeks less? A. That is right. That would have made them 12 weeks through 17 weeks.

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What was the average charge for the 1,160 abortions which were performed by Reproductive Health Services?

Mr. Susman: Objection, Your Honor.

The Court: What is the relevancy?

Mr. Boicourt: Your Honor, we are talking about whether these procedures should be performed in the hospital or not. This witness is the chief executive officer at the facility which is not a hospital, which has performed over a thousand of them in the last 18 months, which has [21] been a very lucrative business and that affects her credibility.

Mr. Susman: Objection, Your Honor. That is argument. I don't think counsel can testify here whether it is lucrative.

Mr. Boicourt: Certainly the financial interest of the witness in the outcome of the litigation is relevant.

The Court: I will permit her to answer, if she knows.

A. The average is in the neighborhood — and I don't have exact figures — of $260.00. The average. There are differences in fees, but the average would be $260.00, for those procedures, 14 through 19 weeks.

Q. So for that 18 months, and again approximately, because you were giving me approximate procedures, Reproductive Health Services has taken in over three hundred thousand dollars for the performance of second trimester abortions? A. I trust your calculations, Mr. Boicourt.

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[23] Q. Do the same operators perform the second trimester abortions as perform the first trimester abortions? Do you make any attempt to assign your more experienced [24] physicians to the second trimester abortions? A. There is basically one physician performing all second trimester abortions. There are nine physicians performing first trimester abortions.

Q. What is the name of the physician performing the second trimester abortions? A. Dr. Robert Christ and Dr. Michael Freeman, who does some of the early second trimesters.

Q. Would it be fair to say those two gentlemen are the most experienced practitioners of dilatation and evacuation employed by your facility? A. That is correct.

Q. Does Reproductive Health Services have blood bank facilities? A. No, sir.

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[25] Q. So hospitals are better equipped to treat infection than Reproductive Health Services? A. That is correct.

Q. Now, when you use the dilatation and evacuation method of [26] performing an abortion, one of the dangers is that the uterus wall will be perforated, is it not? A. That is correct.

Q. Isn't it true that hospitals are better equipped to treat such complications than is Reproductive Health Services? A. To treat, yes. To diagnose, no.

Q. To treat? A. Correct.

Q. They have a blood bank, and you don't? A. That is correct, although the blood bank is not always the issue. Oftentimes not the issue in a perforation.

Q. In any event, if that were to occur, the woman should be treated in a hospital? A. That is correct, and she would be transferred immediately.

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[27] Q. The statistics for the National Center for Disease Control indicate, do they not, that the most common types of complications are hemorrhage and infection? Or are you aware of those particular statistics? A. I have not looked at the most recent statistics. I know hemorrhage is one of the most common.

Q. We agree that hospitals are better equipped to treat hemorrhage than is Reproductive Health Services? A. Yes.

Q. Ms. Widdicombe, I think we can both agree — this might make you happy — that Reproductive Health Services is the most professional, best equipped, and most experienced of all of the abortion clinics in the State of Missouri. Can you agree with that? A. I think so.

Q. So when you testified as to what your results have been, and why you think your results justify your continuing to perform second trimester abortions, you are testifying on behalf of the best of the abortion clinics in the State, is that correct? A. Yes.

Q. Does Reproductive Health Services have any desire to begin performing dilatation and evacuation beyond 19 weeks? A. No, we do not.

[28] Q. Do you think they should be performed in a hospital? A. Yes.

Q. And you do not have any desire or plans to perform saline injection abortions during the second trimester, do you? A. No, I would hope we would never have to refer a woman anyplace for a saline abortion.

Q. If a saline abortion were to be performed, it should be done in a hospital? A. Yes.

Q. Reproductive Health Services does not now and does not plan to perform any abortions by the instillation of prostaglandins, does it? A. Are we talking only about second trimesters?

Q. Yes, second trimesters? A. No, we do not.

Q. If a second trimester abortion were to be given by the instillation of prostaglandins that should be done in the hospital, shouldn't it? A. The problem with that is that prostaglandin is only available to hospitals at this point in time, and it would not even be an alternative where we could discuss it.

Q. Even if it were available to you, don't you agree that since it does induce labor, that if prostaglandins were to be used for abortion purposes, it should be done in a hospital? [29] A. Yes.

Q. Are you aware of statistics of the National Center of Disease Control that indicate in the last year in which statistics were kept nationally and which have been compiled, which was 1978, that only 51 percent of the abortions performed in the second trimester were by dilatation and evacuation? A. That is correct.

Q. Nationwide? A. For 1978, that was correct. There has been a dramatic change in technique in the last two and a half years.

Q. There are no public statistics that indicate the percentages have changed, are there? A. Unfortunately, both state and nationally the reporting mechanisms are about two years behind.

Q. So the answer is no? A. The data is there. There is nothing been published.

Q. So for the last year in which data is available, by your prior testimony, you agree that 49 percent of those second trimester abortions most certainly should have been performed in hospitals? A. If the procedure were the instillation method.

Q. Do not the statistics of the National Center for Disease Control for 1978, again the last year they were compiled, also indicate that not all dilatation and evacuation [30] procedures were performed in the first five weeks of the second trimester? Some physicians and some places were performing D&E after 19 weeks? A. Yes.

Q. So the end result is, is it not, that in 1978, by your own testimony, considerably more than half of all abortions performed in the country should have been done in the hospital? A.

Those were done in hospitals because there were state requirements.

Q. I thought you agreed that a D&E procedure beyond 19 weeks should be done in a hospital? A. If we are talking about breakdown in statistics for 1978, then yes, you are correct.

Q. So for that year, the last year in which statistics are available, the majority of abortions performed in the United States should have, by your own opinion, been performed in a hospital? A. Yes.

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[39] Recross Examination By Mr. Boicourt:

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[46] Q. From your experience it would be dangerous to a woman to perform an abortion at 14 weeks by the instillation of prostaglandins outside of a hospital, would it not? A. Yes.

Q. All right. From your experience, it would be dangerous to perform an abortion at 14 to 15 weeks by the instillation of saline outside of a hospital, would it not? A. It could be more dangerous, yes.

Q. By your own experience, it would be dangerous to perform an [47] abortion in the second trimester by hysterotomy outside of a hospital, would it not? A. Absolutely, Mr. Boicourt. That is a major surgical procedure.

Q. And it would be dangerous to perform a dilatation and evacuation procedure on a woman from 20 to 24 weeks outside of a hospital, would it not? A. As we discussed before, the risk increases with each two weeks of pregnancy. The answer, yes, it would be more dangerous.

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[49] WAYNE SCHRAMM,

called as a witness, being duly sworn, testified:

Direct Examination By Mr. Susman:

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[51] Q. How many hospitals do your records show are presently performing and reporting the performance of second trimester abortions by the D&E method in the State of Missouri? A. There is only one that is definitely performing second trimester D&E's.

Q. Is that institution located within the general Kansas City area? A. Yes, it is.

* * * * * * *

[55] Cross Examination By Mr. Boicourt:

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[57] Q. Mr. Schramm, I think you testified that there was only one hospital in the state that your records disclosed are presently performing D & E procedures in the second trimester, is that correct? A. Correct.

Q. Your records do disclose there are other hospitals in the state providing second trimester abortions, don't they? A. Correct.

* * * * * * *

[61] A. Okay. There is one hospital in the Kansas City area that does — another hospital besides the one mentioned that does second trimester abortions. One in St. Louis area. Our records indicate that there was one out-state, but when we called them, they claimed they did not do second trimester abortions.

Mr. Susman: Just to be clear, you have indicated in addition to the one hospital in Kansas City that does second trimester D & E's, there is another hospital in Kansas City, and another one in St. Louis both who do second trimesters by some method other than by D & E, is that correct?

[62] The Witness: Correct.

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Q. Mr. Schramm, do your statistics in any way reflect hospitals in the State of Missouri which would perform second trimester abortions by D & E? That is, in which there is no regulation written, policy or verbal understanding, which would prohibit same, but they do not reflect whether or not such hospitals exist which would perform those abortions if the statute was upheld, do they?

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[63] Q. (By Mr. Boicourt) Do you understand my question? Your statistics that you keep would not reflect — correct me if I am wrong — the existence of a hospital in the State of Missouri which is available, ready, and willing to perform second trimester abortions via D & E, but which have not done so during the last approximately 18 month period from your statistics, is that correct? A. That is correct.

* * * * * * *

[66] STANLEY HENSHAW,

called as a witness, being duly sworn, testified:

Direct Examination By Mr. Susman:

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[69] A. Yes. I will give you starting from 1980, we have just — we are in the process of completing our survey that covers the years 1979 and 1980. We have completed compiling data from Missouri, although not for the rest of the country. And our figures, our count was, 20,390 abortions occurring in Missouri in 1980; 17,620 in 1979; 15,570 in 1978; and 14,920 in 1977.

Q. Can you give us that same type of information for second trimester procedures only? A. I can give it for 1980 and 1979. Our count of the total number of second trimester procedures performed in the state in 1980 is 1,390; for 1979, 540.

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[71] Q. Will you tell us for the second trimester procedures that you told us you have compiled for '79 and '80, as to how many, percentage-wise, were done in a hospital and how many were done in clinics? A. In 1980, we counted 700 in hospitals and 690 in clinics. In 1979, 540 in hospitals and none in clinics.

Q. Do you also maintain data as to the number of providers? A. Yes, I have that information.

Q. Would you tell us that for '79 and '80? A. All right. For 1979 and 1980, we counted three hospitals that reported one or more second trimester abortions.

Q. Let me stop you for a moment. You report any facility if it has one or more. That becomes a provider, it that correct? A. That is correct.

Q. And you show three hospitals in 1979 and 1980? A. That is correct.

Q. Were they the same three institutions for both years? [72] A. Yes, they were.

Q. Can you tell us, please, the numbers performed by each? A. One reported one second trimester abortion in each of those two years. One reported three abortions in each of those two years. And the remaining hospital reported the remaining abortions, which was about 540 in 1979 and 700 in 1980.

I should point out we round our numbers to the nearest ten, so that the hospital providing three abortions is counted as zero abortions. The figures are not generally perfectly accurate, and rounding them that way, we do that in order to avoid an appearance of accuracy which isn't there.

Q. One hospital which did apparently more than 99 percent of all of the second trimesters in 1979 and 1980, is that in the Metropolitan Kansas City area? A. Yes.

Q. Does the Institute, or do you have reservations about disclosing the name, or do you prefer I not ask you? A. We do not promise confidentiality to our respondents. However, we have a policy not to reveal information provided in the questionnaires if it is not aboslutely necessary.

Q. All right.

Mr. Susman: Excuse me, Your Honor, The parties [73] will stipulate, Your Honor, without the testimony of the witness, that the one hospital referred to is, in fact, Truman Medical Center.

Q. (By Mr. Susman) What significance do you attach — or what additional investigation do you conduct when you have a hospital that reports one procedure, or three procedures? A. Well, we don't do additional investigation. However, we draw the inference that those hospitals are not really making services available to women. The occasional one, or very few procedures, can occur for any number of reasons, such as misdiagnosis of gestation and correct diagnosis afterwards which has been reported to us, or an emergency situation.

Q. All right. A. Let me add in these two cases —

Q. The two cases being the one hospital that did one each year, and the other did three each year? A. That is correct. We have a question on our — questionnaire asking what is generally the maximum gestation — let me read you the question: "What is generally the maximum gestation in weeks since last menstrual period of abortions provided in the hospital?" And in both instances, those hospitals said 12 weeks. That to me indicates they do not generally provide abortions of later gestation.

* * * * * * *

[75] Q. Would you tell us that figure or percentage for the year 1979, when at the time all of the second trimester procedures were being done in a hospital? A. I would have to do a calculation, I am sorry.

In 1979, we would estimate the need for second trimester abortions at 4,030, and the number of second trimester abortions counted in the state was 540. And that [76] percent is 13 percent for 1979.

Q. Would be met at the time when only hospitals were permitted to perform them? A. That is correct.

Q. Have you also calculated the need as of today when both clinics and hospitals are performing second trimester abortions, as to what percentage of the second trimester abortion need for the state of Missouri is presently being met? A. Yes, In 1980 the need met was 34 percent, so it approximately doubled — it approximately tripled.

Q. Am I correct that in each case one would then determine the unmet need by subtracting those figures from 100, would be the reciprocal? A. That is correct.

Q. Are you able to tell us the number of abortions by totals performed that are done in hospitals? A. Yes, The total number of abortions performed in hospitals in 1980 —

Q. This is for the state of Missouri, correct? A. For the state of Missouri, was 1,470. For 1979, 1,330.

Q. How does that translate into percentages? A. In 1980 it is about seven percent of all abortions performed in the state. In 1979, close to eight percent, 7.6 percent.

[77] Q. Does the Institute also compile abortion rates? A. Yes, We calculate abortion rates for states and for the country as a whole.

Q. Would you define the term abortion rates for us as you are using it? A. It is the number of abortions per thousand women of reproductive age. That is per thousand women age 15 to 44 residing in the geographical area.

Q. For the period of 1980 can you tell us what the national abortion rate was?

Mr. Boicourt: Your Honor, that is not relevant to the issues.

The Court: What is the relevancy?

Mr. Susman: The evidence will show that the Missouri rate is less, approximately one-half of the national rate, again going to the question of the unmet need.

The Court: You are offering it solely for that purpose?

Mr. Susman: Yes, Your Honor.

The Court: All right. Overruled.

Mr. Boicourt: 1980? The statute was not in operation in 1980. What effect would that have?

The Witness: We only have data from 1978.

The Court: Whatever the implications are, I [78] will receive it.

Q. (By Mr. Susman) This data is only available for 1978? A. The rate is only available for 1978.

Q. With regard to the rate, what was the national rate? A. 28.2 abortions per thousand women of reproductive age.

Q. How were you defining reproductive age? A. Fifteen to 44.

Q. And for the state of Missouri for the same period? A. It was 14.5 abortions occurring in the state per thousand residents of Misosuri, female residents age 15 to 44.

Q. Does the Institute also maintain statistics on the numberof out-of-state residents who come to Missouri for abortions, and the number of Missouri residents who go to other states to receive the procedure? A. For 1978, we have such estimates.

Q. Would you tell us those, please? A. The number of Missouri residents obtaining abortions out of state in 1978 was 6,990, and the number of residents of other states obtaining abortions in Missouri was 2,380.

Q. So in terms of economics, there was a trade deficit? A. That is correct. Many more Missouri residents went out of state for abortions than residents of other states came to Missouri.

* * * * * * *

[79] A. In Missouri, 49 percent of Missouri women age 15 to 44 live in a county without a provider that is large enough to take self-referred patients. That is, a provider reporting 400 or more abortions a year. In the country as a whole, the percentage is much smaller than that. It is on the order of a fourth or less.

Q. A fourth or less? A. Yes, Less than 25 percent.

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Q. (By Mr. Susman) As I understand it, you indicated that nationally nine percent of all abortions are second trimester procedures? A. That is correct.

Q. Do you have the figure for 1979 at the time when only **[80]** hospitals in Missouri were doing second trimester procedures? What percentage of Missouri abortions were second trimester? A. The figure was about three percent of Missouri abortions for second trimester in 1979.

Q. And in 1980 when both clinics and hospitals were doing them? A. The percentage rose to about seven percent.

Q. Still less than the national average? A. That is correct.

Q. If in fact, all of the abortions done by hospitals in Missouri were second trimesters, every abortion they did was a second trimester abortion, would the need for second trimester abortions in Missouri be met? A. No. it would not. The second trimester abortions would still be only seven percent of the abortions occurring in the state, assuming no clinics were performing such abortions. And the number of second trimester abortions compared to our estimated total need would be still very small, would be less than — about a third.

Q. One final question, Doctor. You indicated now that in 1979, for all purposes really, all of the second trimester abortions in Missouri were being done by one hospital in Kansas City, which the parties have stipulated to be Truman Medical Center.

[81] Now, in 1980, you basically have two second trimester abortion providers in the state. Still Truman Medical and the parties, I think, will stipulate Reproductive Health Services being the clinic in St. Louis, correct? A. Yes.

Q. Did the number of second trimester abortions being done by Truman fall from 1979 to 1980? A. No, it did not. It increased.

Q. Reproductive Health Services when it started doing second trimesters did not draw patients away from Truman? A. No, it did not.

Q. Where did it draw the patients from? A. Evidently it was meeting need for services that had not been met in the state before.

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Cross Examination by Mr. Boicourt:

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[82] Dr. Henshaw, how long has A.G.I. been in existence? A. That is hard for me to say. It has changed form over the years. It was formerly the research and planning division of Planned Parenthood Federation of America and within the last ten years became an independent entity.

Q. So it grew out of an organization, one of whose purposes it is to advocate pro-choice on the part of women who want to have abortions, is that correct? A. I would say one of the purposes of Planned Parenthood is to advocate availability of fertility control services, which includes abortion services.

Q. It is an advocative body? That is, one of its main purposes is to advocate things? A. That is true.

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[88] Q. All right. Would you infer from those figures that Reproductive Health Services in 1980 was substantially meeting all of the need for second trimester abortions in the St. Louis area? A. No, I would not.

Q. Why not? A. There could be any amount of unmet need in the area, even though there is one large provider. I would not — the figures and facts suggest they were not meeting all of the need for services.

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[100] Redirect Examination by Mr. Susman:

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[101] Let me ask you, assuming that every patient who presented themselves at the facility of Reproductive Health Services in St. Louis requesting a second trimester abortion was, in fact, provided with that service. Is that [102] synonymous with the total need for second trimester abortions in the St. Louis Metropolitan area being met? A. No, it is not.

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A. There are any number of reasons why a woman living in the area might not have obtained services from that clinic. She might not have been referred to the clinic or might not know about the clinic, or might have had other reasons for not utilizing that particular clinic. There could be a financial barrier for the use of that clinic. There could be transportation problems such as she was not able to reach the clinic for the period of time necessary to obtain the abortion.

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[103] Q. ... For example, do the women tend to flow for abortion procedures from the smaller towns to the larger cities, or do they flow in the opposite direction into the outstate regions of the bordering state? A. They tend to flow from the smaller towns to the central city area. For example, in the D.C. area, many women go from Virginia to the District of Columbia for abortion services, or from northern New Jersey to New York City or from New Jersey to Philadelphia.

Q. So, in effect, this would increase the numbers of non-Missouri residents being done in the Missouri facilities? A. Yes. You would ordinarily expect Missouri to be serving a large number of out-of-state women from the neighboring states, the metropolitan area in the neighboring states.

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[108] SAMUEL G. EUBANKS, JR.

called as a witness, being duly sworn, testified:

Direct Examination By Mr. Sumner:

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[110] Q. Since 1976, how many second trimester abortions has the office performed? A. Approximately 15,500.

Q. So there is an experience of some 15,500 cases? A. Yes, there is.

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Q. Are you familiar with the practice of outpatient second trimester abortions in the United States? A. Yes, I am.

Q. Would you tell us what is the most common method of performing these outpatient procedures? A. The most common method would be D & E.

Q. Do you have an opinion as to which method of second trimester abortions is the safest for the patient, regardless of whether they are performed inpatient or outpatient? A. Yes, I do.

Q. What is that method? [111] A. I would say the D & E is definitely safer.

Q. Would you tell us whether or not you consider the performance of outpatient D & E abortions during the second trimester to be major or minor surgery? A. It is minor surgery.

Q. Do you feel it is appropriate for an outpatient facility? A. Yes, I do, definitely.

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Q. Do you have an opinion as to at what stage of pregnancy the risks of doing an outpatient D & E procedure are equivalent to those risks associated with normal childbirth? A. Well, probably around 24 weeks from the C.D.C. data.

Q. Would that be consistent with your own experience? A. I haven't actually done them that far, so — but I would believe that.

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[112] Q. Doctor, if you were given a choice and you had ready access to a hospital for the performance of second trimester D & E procedures, or you also had the option of performing them on an outpatient basis, can you tell us which you would select for your patients desiring these procedures? A. I would select the outpatient.

Q. Can you tell us why? A. Well, I personally believe that the outpatient procedure is safer in that there are complications that happen in hospitals that you really can't control. There is the nosocomium infection rate in the hospital. Just organisms that are found in a hospital that are not found on the outpatient basis. And the fact that the patient has to come in contact with some people who might not be too [113] comfortable with her situation, and so there has been on record people that have been abused going through the hospital. I mean mentally anyway, they were not sympathetic to the patients' plight.

Q. Are you saying that when you do them outpatient in your office, for example, you have control over all of your personnel where you don't have that in the hospital? A. Yes, I do.

Q. Is there any comparison or difference in the patients' ability to preserve her anonymity? A. Yes, there is. In the hospital, anonymity is unheard of. It is record, public record then.

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[114] A. Yes, I have. I have done both first trimesters. I have only done the second trimesters in the outpatient facility.

Q. Have you been able to note any difference in anxiety levels during first trimester procedures that are done in hospital or out? A. I feel they are more anxious if they are done in the hospital.

Q. Do you have an opinion as to why that is true? A. Well, part of it could be due just to the individual, but in the outpatient setting, there are other patients that the individual can converse with, and I think the people that she comes in contact with, the working personnel, are more sympathetic to the patient than those in the hospital. And this creates anxiety, the personnel with whom she comes in contact.

Q. Do you have an opinion as to whether this observation would be true for second trimester abortion patients as well? A. Well, I can't say, because I have not had a second trimester in the hospital.

Q. Do you have an opinion as to whether it would be? A. I would think it would be the same.

Q. Do you have any reason to believe it would be different? A. No, I don't.

Q. Can you tell us, please, what effect the presence or absence **[115]** or degree of anxiety in a patient has upon her risk of morbidity or mortality? A. It has a great deal to do with the increase in morbidity and mortality. If the patient is more anxious, she is more likely to suffer an accident during the surgery. Especially if it is done under local anesthesia. The fact that all of her energies aren't directed toward getting better has to come into account. And she just doesn't do as well if she is anxious than if she isn't.

Q. For those patients seeking second trimester abortion procedures, who do not have available to them the clinic situation, and for whatever reasons also do not have ready access to a hospital and therefore have to travel either to another state or to another city to obtain the procedure, do you have an opinion or can you tell us what differences that necessity for travel makes on a patient of this type? A. I think the delay in getting the procedure done will also increase her anxiety, and it is more costly to have to travel somewhere and get the procedure done.

Q. Do you have an opinion as to whether the anxiety, or if there is anxiety, created by the need of having to travel leaving one's personal physician and family at home and having to go to another city? A. Yes, I do. I think all of that increases her anxiety.

[116] Q. How would having to travel from one's normal locale to obtain such a procedure, if at all, affect any post-complication treatment that might be required? A. Well, if she is not around familiar surroundings, if she had to travel away from where she is normally an inhabitant then it would increase her anxiety and she would therefore not have as good an outcome as the individual who is more calm and relaxed.

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Q. ... When there is a complication following a second trimester abortion, everything else being equal, I realize often it is not, is it more appropriate and better for the patient to be treated for that complication by the same physician who performed the original abortion or by a second and different physician? A. Well, I personally like to take care of my own complicatons, if I get them. I know what went on in the first surgery, and if I need a consultant, I can get somebody to help me. But I think the patient is better being treated by that particular physician who did the procedure.

Q. You are familiar with the complications that have been experienced by your office, are you not? [117] A. Yes.

Q. Are you aware of any complications arising from second trimester abortions performed by the D & E method out of this pool or set of some fifteen and a half thousand that have now been done by your office, in which either the delay resulting from a transfer to a hospital, or the actual transfer itself had any adverse impact upon the treatment of that complicaton or the ultimate outcome to the patient? A. No, not at all. In my particular situation I am fairly close to the hospital, but — some of the complications like infection, which is one complication we have had to deal with, it was more than 24 hours before that even occurred, and so even though she had to go into the hospital, we wouldn't have put her right in anyway.

Of course, if during the second trimester abortion one gets a perforation because of the size of the instruments used, one would have to immediately transfer the patient, but I don't believe that would have an effect on the outcome whether or not she needs major surgery or not.

Q. Am I correct in assuming that out of this fifteen and a half thousand patient population that there have been one or more perforations? A. Yes.

Q. Were those perforations transferred to the hospital? [118] A. Yes, they were.

Q. Was, in fact, the transfer itself or the delay engendered by the transfer that in any way adversely impacted the patient's care or form of treatment? A. No, we didn't see any.

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Cross Examination By Mr. Biocourt:

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[119] Q. It is my fault then, because I incorrectly recorded your testimony.

How many of the 15,000 total abortions performed since 1976 were second trimester abortions?

A. Probably 46 percent.

* * * * * * *

[120] Are you aware that for 1978, Doctor, nationally, according to statistics compiled by the National Center of Disease Control, only approximately nine percent of all abortions performed in the United States were done in the second trimester?

A. No, I wasn't familiar with that.

Q. So at your clinic in a state which allows second trimester abortions to be performed outside of hospitals, the rate of second trimester abortions in your experience has been 46 percent? A. Yes, it has.

* * * * * * *

[123] Q. Doctor, I believe you testified also during direct that you have been a plaintiff in a lawsuit in Kentucky dealing with a statute which required second trimester abortions be performed in hospitals, is that correct? A. Yes.

* * * * * * *

[128] Q. In your best medical opinion, any second trimester abortion performed by the instillation of prostaglandins, saline, urea, or some combination, isn't it true that such procedures should be performed in a hospital?

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[131] Q. Doctor, isn't it true that there has been no published control study comparing the relative safety on a statistical basis of hospital and non-hospital second trimester abortions?

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[133] Q. Does your facility have a blood bank, Doctor? A. No, it doesn't.

Q. Do the other abortion facilities of which you are aware, do any of them have blood banks? A. No, they don't.

Q. Do you know of any hospital which does not? **[134]** A. No, I don't.

Q. Isn't it likely in a case of perforation and hemorrhaging, which is a common abortion complication, that a blood bank would be required for treatment of the patient? A. I don't think it is a common complication. In our experience it is less than one percent, you know, of perforations anyway. Hemorrhage can usually be controlled if it is not due to a perforation by giving some uterine contractors or ergotrate, or methergine oxytocin. The average blood loss we have seen has been about 200 to 250 cc's, and with a delivery one loses 500. So we sort of thought about it on that basis, too. You lose much more with a delivery than one does with an abortion.

Q. And deliveries are usually performed in a hospital, is that correct? A. Yes.

Q. Where there are blood banks? A. Yes.

Q. Doctor, isn't it also true that hospitals are better equipped to treat infection than are abortion clinics? A. Well, you need antibiotics, but I mean — if there were going to be an extended period, then you transfer them anyway. The infection would not be that much overwhelming that one could not get to the hospital, so I guess maybe so, yes. Okay. Might be more equipped. But all one has to [135] have, if you have to give an I.V., an intravenous drip and put some antibiotics in it.

Q. Doctor, if you performed an abortion in a clinic on a woman and some 24 hours later perhaps she contracted infection, she likely would come to you first instead of to a hospital, wouldn't she? A. Probably so.

Q. And wouldn't you also speculate, which you have been asked to do by both counsel on direct and cross examination, that the woman who got the abortion in the hospital to begin with and had the infection 24 hours later would go back to the hospital to the physician who treated her? A. Sure, yes. She would go back to her physician.

* * * * * * *

Q. (By Mr. Boicourt) I think maybe I can narrow down your response. In your best medical opinion, isn't it true that a woman having a complication is likely, more likely, to return to the place in which the minor surgery was [136] performed upon her than to go anyplace else for that treatment? A. Yes. She is likely to call that place, right.

Q. Doctor, from your testimony I think it is very clear that you are an extremely experienced practitioner of D & E abortions, will you agree with that? A. I would agree with that.

Q. You have had some four years' practice in the clinic and I take it previous practice before that in hospitals? A. Yes.

Q. Isn't it true that the great majority of OB-GYN's are without your experience? A. I would agree. I would agree.

Q. There is differing qualifications and differing experience factors among OB-Gyn's in the giving of second trimester abortions, is there not? A. I agree with that.

Q. You testified you think it is safe, or perhaps even safer for you to perform an abortion in an outpatient clinic than it would be for the abortion to be performed in a hospital, is that correct? A. Yes, true.

Q. The degree of response to that answer, that is the safeness of the outpatient procedure as compared to the hospital procedure would depend, would it not, upon the **[137]** qualifications, experience, basic quality of the treating physician or the gynecologist? A. Yes, I agree with that.

Mr. Boicourt: No further questions.

Redirect Examination By Mr. Susman:

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[138] Q. (By Mr. Susman) Are you able to detect any demographic **[139]** differences between your patient population who received first trimester abortions and those who come seeking second trimester procedures? A. It seems that — well, if you want to consider social economic factors.

Q. Yes. A. Probably the second trimester are the lowest economic group, or the younger kids, too, they tend to wait longer.

Q. Do you have an opinion as to why that is true, as to why people who are less affluent —

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Q. (By Mr. Susman) Do you have an opinion as to why women who seek second trimester abortions tend to be younger and, as you indicated, less affluent? A. It seems it is as a spectre of denial. They just deny being pregnant, I guess, until it is almost too late.

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[142] Q. ... of time that you have handled them —

The Witness: Yes.

The Court: Is what you have classed as minor surgery?

The Witness: Yes, it is.

The Court: Is there any different opinion about it being minor surgery among the medical profession, to your knowledge, or is the profession pretty well in agreement on that?

The Witness: I think most — especially OB-Gyn would agree it is minor surgery. ...

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[143] The Witness: You can get it in the outpatient facility for about half of what it would be in the hospital.

The Court: Half the dollar cost?

The Witness: Yes.

The Court: So if we have a figure from your experience in about what bracket would that figure lie, dollar-wise?

The Witness: About eight or nine hundred dollars. Maybe a thousand in the hospital. If they did it on an outpatient basis, that is not staying in the hospital, that is still having it in the hospital but then going home right afterwards.

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Opposition

Supreme Court, U.S.
FILED
MAR 26 1982
ALEXANDER L. STEVAS
CLERK

No. 81-1255

IN THE

SUPREME COURT OF THE UNITED STATES

OCTOBER TERM, 1981

PLANNED PARENTHOOD ASSOCIATION OF
KANSAS CITY, MISSOURI, INC.,
NAIM S. KASSAR, M.D., REPRODUCTIVE HEALTH
SERVICES, and ALLEN S. PALMER, D.O.,
Petitioners,
v.
JOHN ASHCROFT, Attorney General of the State of
Missouri, and RALPH L. MARTIN, Prosecuting Attorney
of Jackson County, Missouri,
Respondents.

ON A WRIT OF CERTIORARI TO THE UNITED STATES
COURT OF APPEALS FOR THE EIGHTH CIRCUIT

BRIEF IN OPPOSITION TO PETITION FOR WRIT OF CERTIORARI

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No. 81-1255

IN THE

SUPREME COURT OF THE UNITED STATES

OCTOBER TERM, 1981

PLANNED PARENTHOOD ASSOCIATION OF
KANSAS CITY, MISSOURI, INC.,
NADIM S. KASSAR, M.D., REPRODUCTIVE HEALTH
SERVICES, and ALLEN S. PALMER, D.O.,
Petitioners,

v.

JOHN ASHCROFT, Attorney General of the State of
Missouri, and RALPH L. MARTIN, Prosecuting Attorney
of Jackson County, Missouri,
Respondents.

On a Writ of Certiorari to the United States
Court of Appeals for the Eighth Circuit

BRIEF IN OPPOSITION TO PETITION FOR WRIT OF CERTIORARI

SUPPLEMENTAL STATEMENT OF THE CASE

For purposes of this brief in opposition to plaintiff's petition for certiorari, the respondents, who have themselves filed a cross-petition for certiorari, will not belabor the procedural history and evidentiary background of this proceeding. It is important to note, however, that Section 188.028, RSMo Supp. 1979, is but one section of a comprehensive statutory scheme concerning the subject of abortion which became legally effective on June 29, 1979. Each statutory section of the overall abortion regulation scheme concerned a separate, and separable, facet of the regulation of abortion services. The vast majority of the entire statutory scheme was subjected to litigation by the plaintiffs in the lower courts. The respondents to plaintiffs' petition for certiorari have also filed a cross-petition for certiorari to which the plaintiffs have explicitedly waived their right to file a brief in opposition.

A caveat should be appended to the abbreviated statement of the case included in plaintiffs' petition for certiorari. The statement of the case included in that petition is extremely slanted and argumentative, demonstrating a highly selective rendition of the relevant procedural and evidentiary background of this case. We believe that the Court should read the plaintiffs' statement of the case as part of the argument. It most assuredly is not an unbiased, straight-forward rendition of the facts relevant to this Court's determination as to whether certiorari should be granted.

The defendants, in responding to the plaintiffs' petition for certiorari, do not intend to detail portions of the evidentiary record which are relevant to this Court's determination as to whether certiorari should be granted. Respondents do not believe such a detailed statement of the case is necessary herein, because the determination of whether to grant certiorari will primarily depend upon an entirely legally, as opposed to evidentiary, exercise, *i.e.*, does the decision of the Eighth Circuit approving Missouri Revised Statute Section 188.028 comport with and is it consistent with the most recent and complete statement by this Court concerning the manner in which minors can be required to obtain parental or judicial consent to an abortion as represented by *Bellotti* v. *Baird,* 443 U.S. 622

(1979) (*Bellotti II*). Because the defendants take the position that the decision of the Court of Appeals is entirely consistent with the applicable pronouncements of this Court, as can be amply demonstrated by a comparison of the opinion of the Eighth Circuit with the opinion of this Court in *Bellotti II*, evidence adduced in the trial court is immaterial to the grant of certiorari. To assist the Court in making its determination as to whether the decision of the Court of Appeals is in fact consistent with applicable Supreme Court precedent, there follows an outline of the holding of the Eighth Circuit respecting the constitutionality of Section 188.028. Page references will be to the appendix included in plaintiffs' petition for certiorari.

The Eighth Circuit began its analysis of Section 188.028 by referring to the procedure outlined by Justices Powell, Burger, Reinquist and Stewart in *Bellotti* v. *Baird (Bellotti II)* which would satisfy constitutional requirements. *Id.* at 643-644. (A-65). The lower court then compared the Missouri statutory procedure, as stated in Section 188.028.2(4), RSMo Supp. 1979, with the procedure outlined by the four above-mentioned justices. That statutory procedure requires:

> "(4) In the decree, the court shall for good cause:
>
> (a) Grant the petition for majority rights for the purpose of consenting to the abortion; or
>
> (b) Find the abortion to be in the best interests of the minor and give judicial consent to the abortion, setting forth the grounds for so finding; or
>
> (c) Deny the petition, setting forth the grounds on which the petition is denied;" (A-66-67).

The Eighth Circuit made the logical conclusion that:

> "[I]n the context of the statutory language, a denial of the petition would initially require the court to find

> that the minor was not emancipated and was not mature enough to make her own decision and that an abortion was not in her best interests. These findings and the ultimate denial of the petition must be supported by a showing of "good cause". When the statute is so interpreted and applied it obviates Planned Parenthood's objections. Under these circumstances we find the judicial consent provision of the Missouri statute constitutional." (A-66)

The lower court did not give this statutory section a completely clean slate, however. Section 188.028, also requires, on its face, the serving of notice to all parents of minors who petition for judicial consent to an abortion procedure. That parental consent provision of the Missouri statutory section was invalidated (A-68-69). The Eighth Circuit found that Missouri could not require parental notice, in all cases in which judicial consent to an abortion of a minor was being sought, because the parental consent provisions did not except mature or "best interest" minors from providing notice to their parents prior to a court hearing.

The Court of Appeals approved Section 188.028 as against the claim of plaintiffs that the use of the term "emancipated" as determinative of parental involvement in the abortion decision process was overinclusive, underinclusive, and vague. The lower court concluded that "emancipation" is a sufficiently accurate indicia of dependance on parental advice to serve as the basis for a legislative judgment by the Missouri legislature (A-69).

Finally, the Court of Appeals concluded that the Missouri statutory procedure whereby minors may secure consent to an abortion procedure provides sufficient anonymity to the minor.

Therefore, as modified by the action of the lower court in invalidating the requirement that parental notice be given with respect to all minors seeking judicial consent for an abortion, the Eighth Circuit upheld Section 188.028, rationally concluding that said statutory section is entirely consistent with the pronouncements of this Court in *Bellotti II.* It is with reference to these conclusions by the lower court, and in the context of those conclusions, that plaintiffs' petition for certiorari seeking review of the lower court's ruling concerning the constitutionality of Section 188.028 must be examined.

REASONS FOR DENYING THE WRIT

In arguing that a writ for certiorari to the United States Court of Appeals for the Eighth Circuit should be granted, the petitioners primarily rely upon the assertion that the decision of the Court of Appeals, as it respects the constitutionality of Missouri statutory Section 188.028, is in conflict with the previous decisions of this Court in *Planned Parenthood of Central Missouri* v. *Danforth,* 428 U.S. 52 (1976) and *Bellotti* v. *Baird,* 443 U.S. 622 (1979) *(Bellotti II).* The very reliance by petitioners on *Bellotti II* must doom their attempt to secure Supreme Court review. A true conflict between a decision of a lower court of appeals and a decision by this Court must be a direct and irreconcilable conflict clearly demonstrated on the face of the opinions involved. In this instance, however, the Eighth Circuit was fully aware of the decision of this Court in *Bellotti II* and analyzed the Missouri statute in the context of that applicable Supreme Court precedent. The Eighth Circuit found the Missouri statute to be entirely consistent with *Bellotti II,* except insofar as it required notice to the parents of mature minors or minors whose best interests would be served by an abortion. That portion of the statute, the only provision which the Eighth Circuit found to be inconsistent with the precedent of this Court, was invalidated. As a result, not only does there not remain any clear conflict between the decision of the Eighth Circuit and the opinion of this Court in *Bellotti II*, but the Court of Appeals expressly validated the Missouri statute because it was consistent with the procedure recommended by Justices Powell, Burger, Reinquist and Stewart. *Bellotti II, supra* at 643-644.

It is clear from Supreme Court precedent that the State of Missouri has a protectable interest in insuring that unemancipated minors must secure either parental or judicial consent before they can obtain an abortion. As this Court stated in *Prince* v. *Commonwealth of Massachuetts*, 321 U.S. 158, 166 (1944), "it is cardinal . . . that the custody, care and nurture of the child reside first in the parents." Further, "[o]ur jurisprudence historically has reflected Western Civilization concepts of the family as a unit with broad parental authority over minor children. . . ." *Parham* v. *J. R.*, 442 U.S. 584, 602 (1979). As Mr. Justice Stevens stated in his opinion, concurring in part and dissenting in part, in *Planned Parenthood of Central Missouri* v. *Danforth*, 428 U.S. 52, 101-104:

> "It is unrealistic, . . . to assume that every parent-child relationship is either (a) so perfect that communication and accord will take place routinely or (b) so imperfect that the absence of communication reflects the child's correct prediction that the parent will [act] arbitrarily to further a selfish interest rather than the child's interest. . . ."

The Missouri statute under consideration provides no veto power to parents over a minor's abortion decision. In fact, the statute, as motified by the Eighth Circuit, even obviates the requirement of parental notice for mature minors or minors for whom abortion is in their best interests. Therefore, the Missouri statute differs fundamentally from the Missouri statute struck down in *Planned Parenthood of Central Missouri* v. *Danforth, supra* at 90, which imposed "an absolute limitation on the minor's right to obtain an abortion."

As in the case of the Massachuetts statute made the subject of *Bellotti II,* the Court of Appeals in this case was required to:

> "[R]econcile the constitutional right of a woman, in consultation with her physician, to choose to terminate her pregnancy as established by Roe v Wade, [cites omitted] and Doe v. Bolton, [cites omitted], with the special interest of the State in encouraging an unmarried pregnant minor to seek the advice of her parents in making the important decision whether or not to bear a child. . . ." *Id,* 443 U.S. at 639.

Respondents respectfully submit that the Eighth Circuit properly reconciled the interests at stake, specifically applying the principles announced by this Court in *Bellotti II,* so that a writ of certiorari should not issue. We ask that the Court recall its own caveat that there is "an important state interest in encouraging a family rather than a judicial resolution of a minor's abortion decision," and that a court considering a minor's request for judicial consent for abortion "may deny the abortion request of an immature minor in the absence of parental consultation if it concludes that her best interests would be served thereby, or the court may in such case defer decision until there is parental consultation in which the court may participate." *Id.* 443 U.S. at 648.

The following principles were established by this Court in *Bellotti II:*

> "[T]hat if the State decides to require a pregnant minor to obtain one or both parents' consent to an abortion, it also must provide an alternative procedure whereby authorization for the abortion can be obtained.
>
> A pregnant minor is entitled in such a proceeding to show either: (1) that she is mature enough and well enough informed to make her abortion decision, in consultation with her physician, independently of her parents' wishes; or (2) that even if she is not able to make this decision independently, the desired abortion would be in her best interests. The proceeding in which this showing is made must assure that a resolution of the issue, and any appeals that may follow, will be completed with anonymity and sufficient expedition to provide an effective opportunity for an abortion to be obtained. . . ." *Id.* 443 U.S. at 643-644.

Against the foregoing analysis, the Eighth Circuit determined that it must approve the Missouri statutory section here involved. We submit that this Court should deny the writ based upon similar analysis.

Section 188.028.1(1) requires that in all cases where an abortion is to be performed upon a woman under the age of eighteen years, the attending physician must secure the informed written consent of the minor and one parent, or guardian, *except* that under subsection (2) if the minor is emancipated, the abortion may be performed based solely on the informed written consent of the minor without any parental involvement or notification whatsoever. Further exceptions are embodied in subsection (3) (a) where, if the minor has been granted the right to self consent to the abortion by a juvenile court, no parental consent is required, and in subsection (4) where, if the juvenile court has given judicial consent to the abortion, no parental consent is required. At a juvenile court hearing, the court, pursuant to Section 188.028.2(3) must consider "the emotional development, maturity, intellect and understanding of the minor; the nature, possible consequences, and alternatives to the abortion; and any other evidence that the court may find useful in determining whether the minor should be granted majority rights for the purpose of consenting to the abortion or whether the abortion is in the best interests of the minor; . . ."

Under Section 188.028.2(4) the court may "(a) [g]rant a petition for majority rights for the purpose of consenting to the abortion; . . ." By this, if the court finds that the minor was sufficiently mature to give informed consent to the abortion herself, the court may grant her limited majority rights for that specific purpose. However, if the court finds that the minor is not sufficiently mature, he may nevertheless under subsection (b) "[f]ind the abortion to be in the best interests of the minor and give judicial consent to the abortion, setting forth the grounds for so finding; . . ." As a result, even an unmature minor may be given judicial consent for an abortion, provided that the abortion is in her best interests, regardless of parental consent or the lack thereof.

The third alternative for the juvenile court is under subsection (c) for "*good cause*" to "deny the petition, setting forth the grounds on which the petition is denied; . . ." In that case, there is provision for immediate appeal, and the statute provides further that "[b]ecause time may be of the essence regarding the performance of the abortion, the supreme court of this state shall, by court rule, provide for expedited appellate review of cases appealed under this section." Immediately after the effective date of this statutory enactment, the District Court enjoined enforcement. Therefore, as of this date, and because the petitioners have been granted a stay, Section 188.028 has not been enforced by the State of Missouri and there has been no need, to this point in time, for the state Supreme Court to promulgate rules concerning appellate review.

The defendants/respondents submit that the Missouri statute thereby cures both failings of the Massachuetts provision found unconstitutional in *Bellotti II* because there is no requirement for parental consultation or notification prior to any judicial court proceeding, and there is no opportunity for judicial authorization for an abortion to be withheld where a minor is found to be mature and competent to make the decision independently.

The Missouri statute also avoids the infirmatives present in statutes invalidated in those lower court cases cited by the petitioners in their argument. An examination of the local statutes and ordinances involved in *Akron Center for Reproductive Health, Inc.* v. *City of Akron,* 479 F.Supp. 1172 (N.D.Ohio 1979), and in *Scheinberg* v. *Smith,* 482 F.Supp. 529 (S.D.Fla. 1979) is illustrative. Not only does this statute comport with the guidelines announced in *Bellotti II,* but it is materially different from the ordinance stricken in *Akron Center for Reproductive Health, Inc.* v. *City of Akron, supra.* The Missouri statute exempts emancipated minors altogether, and provides that they may give consent to abortion. The Missouri statute further provides for self-consent for minors who demonstrate to the juvenile court that they are sufficiently mature to make an informed consent. Accordingly, the Missouri statute avoids the fatal flaw in the Akron city ordinance. In *Scheinberg* v. *Smith, supra,* the district court endorsed its order and opinion striking the Florida provision for abortion for unmarried minors as set forth in *Jones* v. *Smith,* 474 F.Supp. 1160 (S.D.Fla. 1979). The Florida statute required:

> "The court shall determine the best interest of the minor and enter its order in accordance with such determination." 474 F.Supp. at 1164.

The district court determined that:

> "The plain reading of the section indicates that the best interest standard overrides any basis for finding good cause under the criteria set forth in the preceding sentences if the judge determines that an abortion is not in the child's best interest. Therefore the statute unconstitutionally allows the judge to deny abortions to minors who are sufficiently mature to give informed consent." *Id.* at 1166.

The respondents respectfully submit that the Missouri statute does not provide the juvenile court with an opportunity to deny consent to abortion where the minor is sufficiently mature to give informed consent. As noted above, the Missouri statute exempts emancipated minors from these provisions altogether, and requires the juvenile court to grant majority rights for consent to abortion where the minor is mature and to give judicial consent to abortion where the abortion would be in the best interest of the petitioning minor. Only for good cause, a legally sufficient cause, may a juvenile court deny consent for abortion. The The Missouri statute, therefore, meets the guidelines of *Bellotti II* while avoiding the problems noted in *Akron* and *Scheinberg* and should be sustained. Similarly, the Missouri statute, as analyzed by the Court of Appeals, avoids the infirmatives present in other statutory provisions considered in the cases which have been cited by the petitioners.

Because the decision of the Eighth Circuit as it concerns Section 188.028, was expressly based on that court's analysis and interpretation of prior Supreme Court precedent, especially *Bellotti II,* there is no conflict between the decision of the lower court and applicable Supreme Court precedent. Therefore, the petition for certiorari must be denied.

CONCLUSION

For these reasons, the petition of plaintiffs for writ of certiorari should be denied.

Respectfully submitted,

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Petitioner’s Brief

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No. 81-1255

IN THE

Supreme Court of the United States

OCTOBER TERM, 1981

PLANNED PARENTHOOD ASSOCIATION OF KANSAS CITY,
MISSOURI, INC., NAIM S. KASSAR, M.D.,
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vs.

JOHN ASHCROFT, Attorney General of the State of Missouri,
and RALPH L. MARTIN, Prosecuting Attorney of Jackson
County, Missouri,
Respondents.

On A Writ Of Certiorari To The
United States Court of Appeals For The
Eighth Circuit

BRIEF OF PETITIONERS

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THE QUESTION PRESENTED FOR REVIEW

Whether the Appellate Court erred in upholding the constitutionality of Missouri Revised Statutes, §188.028.1 and §188.028.2(1), (3), (4), (5) and (6) by construing the same to require statutorily the approval of one parent or of the juvenile court for an unemancipated minor under eighteen years of age to terminate her pregnancy, even if she is found by the juvenile court to be mature enough to make her own personal decision; although such interpretation is contrary to the plain language of the challenged statute and is contrary to the interpretation placed thereon by the District Court?

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No. 81-1255

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OCTOBER TERM, 1981

PLANNED PARENTHOOD ASSOCIATION OF KANSAS CITY, MISSOURI, INC., NAIM S. KASSAR, M.D., REPRODUCTIVE HEALTH SERVICES and ALLEN S. PALMER, D.O.,

Petitioners,

vs.

JOHN ASHCROFT, Attorney General of the State of Missouri, and RALPH L. MARTIN, Prosecuting Attorney of Jackson County, Missouri,

Respondents.

On A Writ Of Certiorari To The
United States Court of Appeals For The
Eighth Circuit

BRIEF OF PETITIONERS

CITATIONS TO OPINIONS AND JUDGMENTS DELIVERED IN THE COURTS BELOW

The initial opinion of the District Court on January 23, 1980 is reported at 483 F.Supp. 679 (W.D.Mo. 1980) and is reprinted in the Petition for Certiorari (No. 81-1255) at A-1 through A-51.

The order of the District Court on May 7, 1980 awarding fees and costs is reprinted in the Joint Appendix at 7-8.

The interlocutory opinion of the Court of Appeals on July 8, 1981 is reported at 655 F.2d 848 (8th Cir. 1981) and is reprinted in the Petition for Certiorari (No. 81-1255) at A-52 through A-108.

The "Opinion on Remand" of the District Court on October 2, 1981 is reprinted in the Joint Appendix at 9-23.

The supplemental and final opinion of the Court of Appeals on November 30, 1981 is reported at 664 F.2d 687 (8th Cir. 1981) and is reprinted in the Petition for Certiorari (No. 81-1255) at A-109 through A-117.

The order of the Court of Appeals on March 12, 1982 awarding fees and costs is reprinted in the Joint Appendix at 36-37.

STATEMENT OF JURISDICTIONAL GROUNDS

The judgment sought to be reviewed was issued and filed on November 30, 1981. The final judgment of November 30, 1981 incorporated the prior interlocutory judgment of July 8, 1981. Jurisdiction of this Honorable Court is predicated upon Title 28 United States Code, § 1254(1) and §2101(c). The Petition for Certiorari was filed on January 4, 1982 and granted on May 24, 1982. (50 U.S.L.W. 3934, May 24, 1982).

CONSTITUTIONAL AND STATUTORY PROVISIONS INVOLVED

The Fourteenth Amendment to the United States Constitution, in relevant part.

> Section 1. All persons born or naturalized in the United States, and subject to the jurisdiction thereof, are citizens of the United States and of the State wherein they reside. No State shall make or enforce any law which shall abridge the privileges or immunities of citizens of the United States; nor shall any State deprive any person of life, liberty,

or property, without due process of law; nor deny to any person within its jurisdiction the equal protection of the laws.

Missouri Revised Statutes, §188.028

188.028. Minors, abortion requirements and procedure

1. No person shall knowingly perform an abortion upon a pregnant woman under the age of eighteen years unless:

(1) The attending physician has secured the informed written consent of the minor and one parent or guardian; or

(2) The minor is emancipated and the attending physician has received the informed written consent of the minor; or

(3) The minor has been granted the right to self-consent to the abortion by court order pursuant to subsection 2 of this section, and the attending physician has received the informed written consent of the minor; or

(4) The minor has been granted consent to the abortion by court order, and the court has given its informed written consent in accordance with subsection 2 of this section, and the minor is having the abortion willingly, in compliance with subsection 3 of this section.

2. The right of a minor to self-consent to an abortion under subdivision (3) of subsection 1 of this section or court consent under subdivision (4) of subsection 1 of this section may be granted by a court pursuant to the following procedures:

(1) The minor or next friend shall make an application to the juvenile court which shall assist the minor or next friend in preparing the petition and notices required pursuant to this section. The minor or the next friend of the

minor shall thereafter file a petition setting forth the initials of the minor; the age of the minor; the names and addresses of each parent, guardian, or, if the minor's parents are deceased and no guardian has been appointed, any other person standing in loco parentis of the minor; that the minor has been fully informed of the risks and consequences of the abortion; that the minor is of sound mind and has sufficient intellectual capacity to consent to the abortion; that, if the court does not grant the minor majority rights for the purpose of consent to the abortion, the court should find that the abortion is in the best interest of the minor and give judicial consent to the abortion; that the court should appoint a guardian ad litem of the child; and if the minor does not have private counsel, that the court should appoint counsel. The petition shall be signed by the minor or the next friend;

(2) Copies of the petition and a notice of the date, time, and place of the hearing shall be personally served upon each parent, guardian or, if the minor's parents are deceased and no guardian has been appointed, any other person standing in loco parentis of the minor listed in the petition by the sheriff or his deputy. If a parent or guardian or, if the minor's parents are deceased and no guardian has been appointed, any other person standing in loco parentis cannot be personally served within two days after reasonable effort, the sheriff or his deputy shall give constructive notice to them by certified mail to their last known address, and the hearing shall not be held for at least forty-eight hours from the time of the mailing. In any case where there exists the potential or appearance of conflict of interests between the parents or guardian or next friend of the child and the child, the court shall appoint a guardian ad litem to defend the minor's interest. The court shall set forth, for the record, the grounds for such appointment;

(3) A hearing on the merits of the petition, to be held on the record, shall be held as soon as possible within five days of the filing of the petition. If any party is unable to afford counsel, the court shall apoint counsel at least twenty-four hours before the time of the hearing. At the hearing, the court shall hear evidence relating to the emotional development, maturity, intellect and understanding of the minor; the nature, possible consequences, and alternatives to the abortion; and any other evidence that the court may find useful in determining whether the minor should be granted majority rights for the purpose of consenting to the abortion or whether the abortion is in the best interests of the minor;

(4) In the decree, the court shall for good cause;

(a) Grant the petition for majority rights for the purpose of consenting to the abortion; or

(b) Find the abortion to be in the best interests of the minor and give judicial consent to the abortion, setting forth the grounds for so finding; or

(c) Deny the petition, setting forth the grounds on which the petition is denied;

(5) If the petition is allowed, the informed consent of the minor, pursuant to a court grant of majority rights, or the judicial consent, shall bar an action by the parents or guardian of the minor on the grounds of battery of the minor by those performing the abortion. The immunity granted shall only extend to the performance of the abortion in accordance herewith and any necessary accompanying services which are performed in a competent manner. The costs of the action shall be borne by the parties.

(6) An appeal from an order issued under the provisions of this section may be taken to the court of appeals of this state by the minor or by a parent or guardian of the minor.

> The notice of intent to appeal shall be given within twenty-four hours from the date of issuance of the order. The record on appeal shall be completed and the appeal shall be perfected within five days from the filing of notice to appeal. Because time may be of the essence regarding the performance of the abortion, the supreme court of this state shall, by court rule, provide for expedited appellate review of cases appealed under this section.
>
> 3. If a minor desires an abortion, then she shall be orally informed of and, if possible, sign the written consent required by section 188.039 in the same manner as an adult person. No abortion shall be performed on any minor against her will, except that an abortion may be performed against the will of a minor pursuant to a court order described in subdivision (4) of subsection 1 of this section that the abortion is necessary to perserve the life of the minor.

STATEMENT OF THE CASE

Missouri Revised Statutes, § 188.028 became law on June 29, 1979, as part of a comprehensive package of abortion regulation contained in Chapter 188. The challenged Section requires the written consent of one parent or of the juvenile court to an abortion for an unemancipated minor under 18 years of age. A temporary restraining order was issued against enforcement of the challenged Section on June 30, 1979.

The District Court declared the challenged Section unconstitutional (483 F.Supp. 679, 687-690 [W.D. Mo. 1980]) (Pet. Cert. A12-A17) and the Appellate Court reversed, holding the Section constitutional (655 F.2d 848, 857-860 [8th Cir. 1981]) (Pet. Cert. A65-A70). (Incorporated into final order of November 30, 1981) (Pet. Cert. A117).

Both Petitioners' and Respondents' witnesses acknowledged that this challenged Section might well engender delays of 13 days or more, forcing many minors to pass into a later stage of pregnancy, thereby exposing them to substantially increased risks of morbidity and mortality. (J.A. 156).

Petitioners' experts were unanimous in their belief that mandating parental involvement in all instances was not in the best interests of the minor, abortion patient population. (J.A. 103, Palmer). "The younger the minor * * * the later she will be in her gestation when she seeks abortion services. The less available the abortion service, the longer she will wait. So it will tend to increase her risks rather than serve her health interest." (J.A. 123, Crist). Dr. Kretzschmar concurred that such a requirement is not "in the best interest of that patient population under the age of 18" (J.A. 127), as did Dr. Vera (J.A. 134).

Respondents' experts also agreed that this challenged Section would on occasion not be in the best interests of the minor. (J.A. 141, Ketterman). Respondents' expert Dr. Nathanson was also concerned with the health risks imposed by the delay he envisioned of "(s)omething on the order of two weeks" (J.A. 145), as was Respondent's expert Dr. Schmidt who acknowledged the possibility of danger in the Section's absolutism (J.A. 154). Respondents' expert Dr. Sym recognized that for a "significant percentage" of minors the delays imposed "would not be in their best health interests" (J.A. 156) and that the challenged Section imposes "a burden upon the delivery and availability of abortion services" (J.A. 156).

Petitioners' expert witnesses detailed the adverse compounding impact this challenged Section would have upon the availability and delivery of abortion services to minors. This would be so because minors delayed by the requirement of parental or judicial consent, also delay initially in seeking medical assistance for abortion by reason of psychological denial, and lack of sophistication and resources. Dr. Crist, drawing upon federal government statistics, testified that "50 per cent of the women age 12 and under who seek abortion services are pregnant by incest". (J.A. 122).

Petitioners' expert witnesses testified that the additional office visit required of minors under §188.028.2(1), prior to seeking court approval, would increase the total cost of the procedure by $10.00 to $25.00, by $35.00 (R. 219, Kassar), $15.00 to $50.00 (R. 350, Crist). They further testified that this challenged Section interferes with the traditional doctor-patient relationship (J.A. 103, Palmer; J.A. 127, Kretzschmar; R. 445, Vera) and seriously burdens the availability and delivery of abortion services (R. 135, Palmer; R. 324, Smith; R. 392, Kretzschmar; R. 446, Vera). Respondents' expert Dr. Ketterman stated in conclusion, "I am not in favor of this law exactly as it is written . . .," it "places a burden upon the delivery and availability of abortion services." (J.A. 141). Respondents' expert Dr. Nathanson also stated he could not support this challenged Section requiring parental involvement in all cases, thereby removing from the physician the ability to act in each case for the best interests of his or her patient. (J.A. 144-45).

It was Dr. Smith's considered opinion that "the minor herself is the best judge of whether her parents should be notified or not before she consents to abortions." (R. 313). Respondents' expert Dr. Sym approved of the Section in backhanded fashion, for he felt that a physician could fail to comply with it "if the doctor had a very good reason" and later "he would be able to defend himself against these charges successfully". (J.A. 156). He acknowledged that "many parents would fail to support a minor's decision to abort." (J.A. 156).

No two witnesses in the entire trial could agree on what the term "emancipated" in §188.028.1(2) means, and the same is not defined by the statute. Dr. Palmer had no idea of the criteria for emancipation (J.A. 103) and was aware of 14 year old women capable of giving an informed consent (J.A. 104). Dr. Kassar questioned "(i)f the person can calculate up to ten * * * * or tell me a good joke * * * * I don't understand it." (J.A. 110). "I wouldn't know how to determine that. * * * * It is confusing." (J.A. 118, Smith). "I wouldn't know how to use the emancipated portion of it." (J.A. 122, Crist). "It confuses me." (J.A. 133, Vera).

Respondents' experts were equally perplexed. "(A) young woman who is in any way still in need of guidance and advice and help from her parents * * * * is not truly an emancipated person * * * * (f)or the purposes of this section" (J.A. 138, Ketterman). As far as the definition of emancipated "I am really lost" (J.A. 140, Ketterman). "(E)ither marriage or prior birth is determinant" of emancipation (J.A. 145, Nathanson). "I can only guess," there would have to be "a prior legal proceeding in which the minor has been officially adjudicated to be emancipated." (J.A. 156, Sym).

The built-in delays of this challenged Section are enormous. A typical pattern of *prompt* compliance might well reflect the following: A minor, who previously having realized her pregnant state, having consulted her parents and having been refused consent, receiving the required information from the facility all on delayed day one. She must then file pleadings with the court on day two (§188.028.2[1]), allow for service on her parents on days three and four (§188.028.2[2]), allow for mailing or notice on days five and six (§188.028.2[2]), have a court hearing and decision on day seven (§188.028.2[3]-[4]), have an appeal filed on day eight (§188.028.2[6]), allow for perfection and decision on appeal on days nine through 14 (§188.028.2[6]) and then await an indeterminable period of time for an appellate decision and any subsequent appeal processes.

No other Missouri statute exists regulating any other medical or surgical procedure in this fashion; and this challenged Section applies to abortion at all stages of pregnancy. Dr. Kassar related the Missouri experience in 1974-1976 when parental involvement was mandated.

> First the patient went out of the state and * * * * we lost her. Second, the patient always comes late by the time they tell their parents. Third, some kids got kicked out of home, and, you know, some come with bruised eyes after they told their parents, and they come late. And some they never told their parents and they run away. (J.A. 109-10).

Dr. Smith related a case in which the parent refused consent to the minor because the parent wanted the child to raise and a three week delay ensued. (R. 296). Dr. Crist was also concerned that mandated "parental involvement would jeopardize * * * *" the minor patient's "well being." (J.A. 122). He felt that parental involvement in such cases "would increase her anxiety * * * *" and "the greater her anxiety and changes in body metabolism, her ability to cooperate with the medical setting, those contribute to an increased risk of complications and problems." (J.A. 123). As Respondents' expert Dr. Ketterman observed, "young women have gone into labor, a full-term pregnancy * * * * never having admitted to themselves or anyone else that they were pregnant." (J.A. 136).

The basis for federal court jurisdiction of this matter in the first instance was Title 28, United States Code, §1343(3) and Title 42, United States Code, §1983. (483 F.Supp. at 682, Pet. Cert. A1).

SUMMARY OF ARGUMENT

The statutory interpretation of Missouri Revised Statutes, §188.028.2(4) imposed by the Appellate Court is contrary to any reasonable interpretation of the same, contrary to grammatical and statutory rules of construction and contrary to the well-reasoned opinion of the District Court and other courts interpreting similar provisions.

The juvenile court is authorized after hearing and for good cause shown to:

> (a) Grant the petition for majority rights for the purpose of consenting to the abortion; or
>
> (b) Find the abortion to be in the best interests of the minor and give judicial consent to the abortion, setting forth the grounds for so finding; or
>
> (c) Deny the petition, setting forth the grounds on which the petition is denied.

(MO.REV.STAT., §188.028.2(4)).

The authority of the juvenile court is to do *either* (a), *or* (b), *or* (c). No reasonable requirement nor interpretation can be imposed upon the statutory language that a denial of the petition (c) "would initially require the court to find that the minor was not emancipated and was not mature enough to make her own decision and that an abortion was not in her best interests." (655 F.2d at 858, Pet. Cert. A 66).

The challenged Section's use of the term "emancipated" offers no guidance whatever as to its appropriate application, particularly in the criminal context; as evidenced by the fact that all of Petitioners', as well as Respondents', witnesses were at a loss to understand and to agree upon its meaning. The standard of vagueness for criminal statutes affecting fundamental constitutional rights is violated by the Appellate Court's opinion interpreting the challenged Section.

ARGUMENT

I.

The Clear Meaning Of The Statutory Language

> . . . . there are few situations in which denying a minor the right to make an important decision will have consequences so grave and indelible. *Bellotti* v. *Baird,* 443 U.S. 622, 642 (1979).

This challenged Section attempts to impede and to frustrate abortions for minors by forcing them to wend their way through a maze of parental and judicial involvement, necessitating requirements, loss of anonymity and delays adverse to their best health interests. Women under the age of 18 constitute a large portion of the abortion population. Twenty-eight percent of Petitioner Reproductive Health Services' patients are under 18 years of age. (J.A. 95, Widdicombe). In Dr. Kretzschmar's practice, as Chair of Obstetrics and Gynecology at both Truman Medical Center and at the University of Missouri Medical School at Kansas City, 65% of the patients are under 18 years of age (J.A. 126) and in Petitioner Dr. Palmer's practice, one-third (J.A. 104). State-wide, the percentage is 14.1. *Trends in Missouri Abortions 1975-1980,* Missouri Center for Health Statistics Publication No. 4.25, June, 1982, Table 12, supplemental unnumbered sheet for 1981.

Minors delay seeking medical assistance, thereby increasing the dangers to their health, by reason of "the requirement of parental consent." (J.A. 97, Widdicombe).

This challenged Section blatantly violates the specific holdings of this Honorable Court in *Planned Parenthood of Central Missouri* v. *Danforth,* 428 U.S. 52 (1976) and in *Bellotti* v. *Baird,* 443 U. S. 622 (1979) (*Bellotti, II*).

Initially in 1974, Missouri sought to require parental consent for all unmarried minors under the age of 18. This Honorable Court in *Danforth* struck down that provision in 1976 noting,

> * * * the State does not have the constitutional authority to give a third party an absolute, and possibly arbitrary, veto over the decision of the physician and his patient to terminate the patient's pregnancy, regardless of the reason for withholding the consent.
>
> * * * *
>
> Any independent interest the parent may have in the termination of the minor daughter's pregnancy is no more weighty than the right of privacy of the competent minor mature enough to have become pregnant.

428 U.S. at 75.

In response to this Honorable Court's decision, Missouri enacted the present challenged Section. The thrust of this effort is again to frustrate the exercise by minors of their constitutional rights, by requiring the unnecessary encumbrances of parental and/or judicial confrontation. What this Honorable Court said in 1976 is equally true today with regard to §188.028. Even the State itself may not retain the arbitrary right of veto over a mature minor's abortion; and parental interests of any level may never outweigh the minor's interests of privacy.

The statute in *Planned Parenthood of Central Missouri* applied only "if the woman is unmarried and under the age of eighteen years." 428 U.S. at 85. The challenged statute here does not except married women under the age of 18 who may not be "emancipated." This Honorable Court observed in *Planned Parenthood of Central Missouri*:

> It is noted that in Missouri a woman who marries with parental consent under the age of 18 does not require

> parental consent to abort, and yet her contemporary who has chosen not to marry must obtain parental approval.

428 U.S. at 73. The statute in *Bellotti, II,* also pertained only "(i)f the mother is less than eighteen years of age and has not married." 443 U.S. at 625. Similarly, the parental notice requirement in *H.L.* v. *Matheson,* 450 U.S. 398, 400 (1981) applied only to unmarried minors.

In *Bellotti, II,* this Honorable Court held invalid a Massachusetts statute, which is almost identical to this challenged Section, the latter having been enacted weeks prior to that decision and having become effective three days prior to the decision in *Bellotti, II.*

> Although it satisfies constitutional standards in large part, §12S fails to meet constitutional muster in two respects: First, it permits judicial authorization for an abortion to be withheld from a minor who is found by the superior court to be mature and fully competent to make this decision independently. Second, it requires parental consultation or notification in every instance, without affording the pregnant minor an opportunity to receive an independent judicial determination that she is mature enough to consent or that an abortion would be in her best interests.

Bellotti, II, 443 U.S. at 651.

Both of these constitutional infirmities are present throughout this challenged Section. As Respondents' own expert witnesses acknowledged, §188.028.2(4) permits the court to deny the minor's petition, even though she may be capable of giving her own consent. (J.A. 104-05, Ketterman). The permissible orders by the court under §188.028.2(4) in subsections (a) through (c) *are all independent alternatives, joined by the disjunctive "or."*

Parental involvement was mandated and envisioned by the Missouri General Assembly at all stages and in all cases, regardless of the minor's best interest. See: §188.028.1(1), and §188.028.2(1), (2), (5) and (6).

> Moreover, the potentially severe detriment facing a pregnant woman, see *Roe* v. *Wade,* 410 US at 153, is not mitigated by her minority. Indeed, considering her probable education, employment skills, financial resources, and emotional maturity, unwanted motherhood may be exceptionally burdensome for a minor. In addition, the fact of having a child brings with it adult legal responsibility, for parenthood, like attainment of the age of majority, is one of the traditional criteria for the termination of the legal disabilities of minority. In sum, there are few situations in which denying a minor the right to make an important decision will have consequences so grave and indelible.

Bellotti, II, 443 U.S. at 642.

Similar provisions for minors' consents as contained in §188.028 have been declared unconstitutional by the Seventh Circuit, for reasons similarly applicable here. In *Wynn* v. *Carey,* 582 F.2d 1375 (7th Cir. 1978), an unanimous Appellate Panel held,

> The State's concern that a minor receive parental guidance about a prospective abortion is undermined when a significant segment of pregnant minors is not afforded that guidance. In short, the statute distinguishes between two classes of minors without any showing of jusification for the distinction.
>
> * * * *
>
> * * * * a pregnant minor who chooses to give birth may consent to any medical or surgical treatment without the necessity of parental consent* * * * That legislation presumes that pregnant minors are sufficiently knowledge-

> able and mature to consent knowingly. The State has suggested no reason why pregnant minors are less capable of deciding whether to terminate their pregnancy than they are to decide whether to carry their pregnancy to term, or even to have a Caesarian section, a far more dangerous procedure than a first trimester abortion. We hold, therefore, that the Act, at least in regard to the objective of the informed decisions, is underinclusive because it excludes married minors and overinclusive because it includes mature and emancipated minors.

582 F.2d at 1387.

The challenged Section in this cause suffers identical infirmities to the *Wynn* statute. In Missouri, any minor can consent, without parental or judicial concurrence, to carry a pregnancy to term, regardless of her emancipation. Missouri Revised Statutes, §431.061.1(4)(a). This challenged Section is underinclusive for its excludes minors who have left or deserted their parents' home and live alone, regardless of their age, maturity, intelligence, education or experience; and, in fact, encourages pregnant minors to flee their family and homes to obtain summarily the status of emancipation. It is overinclusive for it includes minors who may be married, divorced or widowed with prior children, if they remain unemancipated by living with their parents, dependent upon them for support.

The Appellate Court in *Wynn,* noted that,

> The parents' right to know is therefore in direct conflict with the minor's right of privacy....such notice frequently might be inconsistent with a minor's best interests.[24] That it may not be in the minor's best interest to have her parents informed of her condition in all cases is recognized by the Illinois General Assembly. A number of statutes

> enable minors to receive medical care without the parents being informed. For example, a minor can receive birth control devices and treatment for venereal disease and drugs use without parental notice. * * * * Legislation of this type recognizes that in certain situations when minors may be hesitant to inform their parents of their condition, enabling those minors to obtain counseling and medical care without involving their parents may not only be in their best interests but may also serve the public interest in assuring that medical care is provided.
>
>> 24. There are a variety of reasons why it could be inconsistent with a minor's best interests to have one or both of her parents know of her pregnancy. For example, parents may physically abuse the minor upon disclosure of the pregnancy. Rather than inflicting physical harm, parents may force the pregnant minor to enter into a marriage which she does not want. Others may compel the minor to continue her pregnancy simply as punishment.

582 F.2d at 1388. See the complete, extended discussion in *Wynn,* 582 F.2d at 1388-1390.

The Missouri General Assembly similarly has determined that minors should be allowed treatment for drug, pregnancy and venereal disease, free from parental involvement. Missouri Revised Statutes, §431.061.1(4)(a-c).

The omission of the word "health", in conjunction with the word "life" as included in the last line of §188.028.3 is also fatal to subsection 3. See: *Roe* v. *Wade,* 410 U.S. 113, 165; and, *Planned Parenthood of Central Missouri,* 428 U.S. at 68 at note 9.

The suggestion in *dicta* by Justice Powell (Justice Stewart concurring) in *H.L.* v. *Matheson,* 450 U.S. 398, 412-13 (1981) that "the *medical* decisions (of childbirth) to be made entail few — perhaps none — of the potentially grave emotional and psychological consequences of the decision to abort" is untrue. (Parenthetical material supplied). In fact, "the psychosis rates, between women who have abortions and the women who carry to term, the rate of psychosis is ten times....(greater) for women who carry to term." (R. 305). (Parenthetical material supplied).

The overall safety of abortion compared to childbirth is also of tantamount concern. The relative safety of abortion to childbirth has dramatically increased since this Honorable Court's observation "of the now-established medical fact....that until the end of the first trimester mortality in abortion may be less than mortality in normal childbirth." *Roe* v. *Wade,* 410 U.S. 113, 163 (1973).

> At eight or fewer weeks' gestation, when more than half the procedures are performed, the risk of death from abortion was more than 20 times lower than that of childbearing. This difference declines as gestational age increases, but abortion remains the safer procedure with respect to the woman's life at gestational ages at least up through 16 weeks.

Cates, *et al.,* "Mortality from Abortion and Childbirth", **The Journal of the American Medical Association,** Vol. 248, No. 2, July 9, 1982, pp. 188, 191.

Bellotti, II, imposed one additional requirement upon statutes which attempt to establish an alternative judicial bypass for parental consent.

> The proceeding in which this showing is made *must assure* that a resolution of the issue, *and any appeals* that may follow, *will be completed with anonymity and sufficient expedition to provide an effective opportunity for an*

> *abortion to be obtained.* In sum, *the procedure must ensure* that the provision requiring parental consent does not in fact amount to the "absolute, and possibly arbitrary veto" that was found impermissible in Danforth.

443 U.S. at 644. (Emphasis supplied).

The challenged Section's provisions do not in any manner *ensure* a prompt determination at either the trial court level (§188.028.2[4]) nor at the appellate level (§188.028.2[6]). In fact, regarding appeals, the matter of expedition is relegated to the future adoption of court rules by the State Supreme Court, contrary to the express command of this Honorable Court that such assurances be contained in the statute. No such rules have been enacted in the more than three years which have elapsed since the statute's enactment. Neither is anonymity *ensured* on appeal (nor at the trial level) by the challenged Section.

Numerous courts have interpreted and/or stricken identical provision for many of the reasons enunciated in the District Court's well-reasoned opinion. (483 F.Supp. at 687-690, Pet. Cert. A12-A17). See: *Jones* v. *Smith,* 474 F.Supp. 1160, 1164-67 (S.D.Fla. 1979), *affirmed* sub nom. *Scheinberg* v. *Smith,* 659 F.2d 476, 478-82 (5th Cir. 1981). *Akron Center For Reproductive Health, Inc.* v. *City of Akron,* 479 F.Supp. 1172, 1201-02 (N.D.Ohio 1979), *affirmed,* 651 F.2d 1198, 1205-06 (6th Cir. 1981), *cert. granted,* 50 U.S.L.W. 3934 (May 24, 1982); *Charles* v. *Carey,* 627 F.2d 772, 775 at n.2 (7th Cir. 1980); and *Baird* v. *Attorney General,* 371 Mass. 741, 748 (1977), 360 N.E.2d 288, 293.

> We shall not belabor the constitutional question section 390.001(4)(a) presents, as the Supreme Court has resolved that issue. In *Bellotti* v. *Baird,* 443 U.S. 622, 99 S.Ct. 3035, 61 L.Ed.2d 797 (1979), the Court held that a state may require, alternatively, parental consent or judicial authorization before allowing an unmarried minor to secure an

> abortion. The Court specified, however, that judicial authorization *must* be given if the minor "satisfies the court that she is mature and well enough informed to make intelligently the abortion decision on her own," *id.* at 647, 99 S.Ct. at 3050, *or* if, absent this showing, the court determines that the abortion would nevertheless be in the minor's best interest. *Id.* at 647-48, 99 S.Ct. at 3050.
>
> As we read subsection 4(a), its last sentence, "[t]he court *shall* determine the best interest of the minor and enter its order in accordance with such determination" (emphasis added), mandates that a Florida court base its authorization of a minor's abortion on what it finds to be the best interests of the minor, without regard to the minor's maturity. Thus, the provision runs directly afoul of *Bellotti II,* for "it permits judicial authorization for an abortion to be withheld from a minor who is found by the . . . court to be mature and fully competent to make this decision independently." *Bellotti II* at 651, 99 S.Ct. at 3052. If we reach the merits of plaintiff's claim, therefore, it is clear that subsection 4(a) must fall.

Scheinberg, 659 F.2d at 480.

While the tortured construction of §188.028 by the Appellate Court might well produce a result permitted by *dicta* of *Bellotti II,* it is clear that the District Court, as have numerous other courts, correctly interpreted the specific statutory language of §188.028 to condone results constitutionally impermissible and results which are directly counter to the admonitions of *Bellotti, II.*

The fault found by this Honorable Court with the parental veto in *Planned Parenthood of Central Missouri* is equally applicable here.

> .... it imposes a special-consent provision, exercisable by a person other than the woman and her physician, as a prere-

> quisite to a minor's termination of her pregnancy and does so without a sufficient justification for the restriction. It violates the strictures of Roe and Doe.

428 U.S. at 75.

Recent decisions by this Honorable Court reaffirm the time honored and constitutionally mandated principle that courts shall not act as superlegislatures and seek to redraft statutes under the guise of construction.

> * * * * it is an elemental canon of statutory construction that where a statute expressly provides a particular remedy or remedies, a court must be chary of reading others into it. "When a statute limits a thing to be done in a particular mode, it includes the negative of any other mode."

Transamerica Mortgage Advisors, Inc. v. *Lewis,* 444 U.S. 11, 19-20 (1979). See: *Kissinger* v. *Reporters Committee for Freedom of the Press,* 445 U.S. 136, 149 (1980). Where the legislative "will has been expressed in reasonably plain terms, 'that language must ordinarily be regarded as conclusive'." *Griffin* v. *Oceanic Contractors, Inc.,* 50 U.S.L.W. 5026, 5028 (June 30, 1982).

It is imperative to recognize that the challenged Section was not an effort by the Missouri General Assembly to track faithfully this Honorable Court's opinion in *Bellotti II,* decided on July 2, 1979. The challenged Section was passed by the Missouri General Assembly two weeks earlier on June 15, 1979. It is only by reason of the labored construction placed upon the challenged Section by the Appellate Court, a construction that defies normal rules of grammar and customary definitions of words, a construction that strains in Procrustean fashion to bed the challenged Section to a subsequent opinion by this Honorable Court, that the challenged Section approaches the semblance of constitutional validity.

The Appellate Court noted that the standing problems of mature, emancipated and "best interests" minors, present in *H.L.* v. *Matheson,* 450 U.S. 398 (1981), were not present here. (655 F.2d at 858-59). (Pet. Cert. A67-A68). This Honorable Court's appreciation that "parents have an important 'guiding role' to play in the upbringing of their children" (**H.L.**, 450 U.S. at 410), cannot overshadow the critical decision of the minor child to have an unimpeded right to decide not to bear children at any given stage of **her** life.

This Honorable Court's appropriate recognition of the positive imput by parents of the pregnant minor in many cases and of the importance of family unity must never be allowed to override the concurrent recognition of these factors as they pertain to the family in formation; that of the pregnant minor and the fetal life she bears. She alone, and not her parents, will have sole responsibility, legal obligations and liabilities towards and for any child to be borne.

As the District Court so aptly stated:

> This Court is unable to subscribe to defendants' reading of the statute. Although the juvenile court is authorized to select one of three alternatives, each of the three is clearly independent of the others, connected in the statute with the disjunctive "or." Alternative (c) permits the court to "deny the petition," guided only by the general standard that such action be "for good cause." Defendants suggest that the legislative intent is clear that the juvenile court may deny the minor's petition *only* if it finds that an abortion is not in the best interests of the minor *and* that the minor is not competent to decide for herself. *Such an intent is not evident in the statute nor was any such showing made at trial.* It is clear to this Court that alternative (c) authorizes the juvenile court to deny the minor's petition for good cause, but does not require a prior finding that

> the minor is not sufficiently mature and not competent to make a decision regarding abortion independently.

(483 F.Supp. at 689, Pet. Cert. A16) (Emphasis supplied).

The Appellate Court agreed with the legal standard applied by the District Court; but without any discussion or explanation held "that in the context of the statutory language, a denial of the petition would initially require the court to find that the minor was not emancipated and was not mature enough to make her own decision and that an abortion was not in her best interests." (655 F.2d at 858, Pet. Cert. A66).

II.

The Due Process Violation By Reasons Of Vagueness And Lack Of Specificity

> .... a statute which either forbids or requires the doing of an act in terms so vague that men of common intelligence must necessarily guess at its meaning and differ as to its application, violates the first essential of due process of law. *Connally* v. *General Construction Company,* 269 U.S. 385, 391 (1926).

The Appellate Court's reference (655 F.2d at 860 n.15, Pet. Cert. A70) to *Wurth* v. *Wurth,* 322 S.W.2d 745, 746 (Mo. 1959) offers little guidance or relevance.

> .... the parents must consent or agree that a minor child be emancipated and unless the parents so give their consent, the child retains the status of an unemancipated minor.

The question of a minor's emancipation under Missouri law abounds with confusion.

> Emancipation has been defined as the "freeing of a child for all the period of its minority from the care, custody, control, and service of its parents; the relinquishment of

> parental control, conferring on the child the right to its own earnings and terminating the parent's legal obligation to support it." 67 C.J.S. Parent and Child § 86, page 811. Emancipation may be accomplished by express or implied agreement but it is never presumed and the burden is upon him who would assert it.

In re the Marriage of Heddy, 535 S.W.2d 276, 279 (Mo. App. E.D. 1976). "Emancipation can be accomplished by either expressed or implied consent of both parents or a custodial parent." *Black* v. *Cole*, 626 S.W.2d 397, 398 (Mo. App. W.D. 1981).

> A minor's emancipation results from his or her parents relinquishing parental control, which may be inferred from a child's attaining a status or position inconsistent with remaining subject to parental care and control, *id.*, and from such things as parental acquiescence in the child's working for others, receiving its pay therefor, and spending the money as it pleases.

Rapplean v. *Patterson*, 631 S.W.2d 693, 694 (Mo. App. E.D. 1982).

The total confusion engendered by use of the term "emancipated" to both witnesses for Petitioners, as well as witnesses for Respondents is well documented *supra*, at 8-9. Physicians are the very individuals subject to the criminal sanctions imposed by this vagueness quandry.

In *Grayned* v. *City of Rockford*, 408 U.S. 104, 108-09 (1972) this Honorable Court formalized several standards of the "void for vagueness" doctrine:

> Vague laws offend several important values. First, because we assume that man is free to steer between lawful and unlawful conduct, we insist that laws give the person of ordinary intelligence a reasonable opportunity to know what

> is prohibited, so that he may act accordingly. Vague laws may trap the innocent by not providing fair warning. Second, if arbitrary and discriminatory enforcement is to be prevented, laws must provide explicit standards for those who apply them. A vague law impermissibly delegates basic policy matters to policemen, judges, and juries for resolution on an *ad hoc* and subjective basis, with the attendant dangers of arbitrary and discriminatory application. Third, but related, where a vague statute "abut(s) upon sensitive areas of basic First Amendment freedoms," it "operates to inhibit the exercise of (those) freedoms." Uncertain meanings inevitably lead citizens to " 'steer far wider of the unlawful zone'... than if the boundaries of the forbidden areas were clearly marked."

The most "stringent vagueness test should apply," where as here the challenged law "threatens to inhibit the exercise of constitutionally protected rights." *Village of Hoffman Estates* v. *Flipside, Hoffman Estates, Inc.,* ____ U.S. ____, 71 L.Ed.2d 362, 372 (1982).

CONCLUSION

The number of abortions performed for minors under 18 years of age has been decreasing in Missouri since 1979 and the ratio of pregnancies terminated, while increasing from 1975 to 1979, has remained static since 1979. *Trends in Missouri Abortions 1975-1980,* Missouri Center for Health Statistics Publication No. 4.25, June 1982. Table 11 at 30, 36, 42, 48, 54, 60 and supplemental unnumbered sheet for 1981.

The abortion experience in Missouri after 1974 has proven satisfactory to patients, their families and physician providers. To disrupt the *status quo* through the unwarranted interjection of the judicial process will cause undue hardship and turmoil upon all parties involved, including the courts.

Despite the best efforts of the Appellate Court to rewrite the challenged Section 188.028 under the pretense of statutory construction; its zealous intrusion into the legislative process can not be condoned. The Missouri General Assembly's ill-timed enactment, weeks before the enlightenment offered by this Honorable Court in *Bellotti, II,* can not be saved by a blurring of the lines delineating the separate branches of government.

The Missouri General Assembly is free to pass appropriate legislation governing minors and abortions, which comports with constitutional requirements. It has failed to do so in this instance and to date.

WHEREFORE, Petitioners pray that a Writ of Certiorari be issued to the Eighth Circuit Court of Appeals, reversing the judgment of that Appellate Court which sustained the constitutionality of Missouri Revised Statutes, §128.082.1 and §128.028.2(1), (3), (4), (5) and (6), and for such further orders as this Honorable Court deems appropriate.

Respectfully submitted,

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Nos. 81-1255 and 81-1623

IN THE

SUPREME COURT OF THE UNITED STATES

OCTOBER TERM, 1981

PLANNED PARENTHOOD ASSOCIATION OF
KANSAS CITY, MISSOURI, INC.,
NAIM S. KASSAR, M.D., REPRODUCTIVE HEALTH
SERVICES and ALLEN S. PALMER, D.O.,
Petitioners and Cross-Respondents,

v.

JOHN ASHCROFT, Attorney General of the State of
Missouri, and RALPH L. MARTIN, Prosecuting Attorney
of Jackson County, Missouri,
Cross-Petitioners and Respondents.

On a Writ of Certiorari to the United States
Court of Appeals for the Eighth Circuit

BRIEF FOR THE CROSS-PETITIONERS

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QUESTIONS PRESENTED FOR REVIEW*

1. Whether the State of Missouri may require by statute that every abortion performed subsequent to the first twelve weeks of pregnancy be performed in a hospital.

2. Whether the State of Missouri may require by statute that a tissue sample be taken of every abortion and submitted to a qualified pathologist for a pathology report.

3. Whether the State of Missouri may require by statute the attendance of a second physician, in addition to the primary surgeon, before an abortion of a viable fetus may be performed.

4. Whether an award of attorneys' fees, made pursuant to Title 42 U.S.C. §1988, should be proportioned to accurately reflect the extent to which a plaintiff prevails.

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*This brief on the merits is addressed to the four questions with respect to which the cross-petitioners sought certiorari to the United States Court of Appeals for the Eighth Circuit. The Court has also granted certiorari to the petitioners, plaintiffs in the trial court, with respect to one question. The Plaintiffs' opening brief will address the question which they presented for Supreme Court review. The responsive brief of the defendants, cross-petitioners and respondents in this Court, will address the question presented by the plaintiffs. That question has not been included as a question presented for review for purposes of this brief.

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of Jackson County, Missouri,
Cross-Petitioners and Respondents.

ON A WRIT OF CERTIORARI TO THE UNITED STATES
COURT OF APPEALS FOR THE EIGHTH CIRCUIT

BRIEF FOR THE CROSS-PETITIONERS

OPINIONS BELOW

The primary decision of the United States District Court for the Western District of Missouri is reported at 483 F.Supp. 679 (W.D.Mo. 1980) (Cross-Pet.App. A at A-1-53).

An interlocutory opinion of the United States Court of Appeals for the Eighth Circuit is reported at 655 F.2d 848 (8th Cir. 1981) (Cross-Pet.App. B at A-54-112).

The opinion on remand of the District Court is unreported (A 9-23).

The supplemental opinion of the Eighth Circuit, making the judgment of the Court of Appeals final, is reported at 664 F.2d 687 (8th Cir. 1981) (Cross-Pet.App. C at A-113-121).

JURISDICTION

The final decision of the Court of Appeals (Cross-Pet. App. C at A-113-121) was entered on November 30, 1981. That final decision and order incorporated specific findings and conclusions of a prior interlocutory judgment (Cross-Pet.App. B at A-54-112), filed on July 8, 1981. The cross-petition for a writ of certiorari was docketed in this Court on March 1, 1982. The jurisdiction of this Court rests upon Title 28 U.S.C. §1254(1).

CONSTITUTIONAL AND STATUTORY PROVISIONS INVOLVED

"Fourteenth Amendment to the United States Constitution, Section 1:

> "All persons born or naturalized in the United States, and subject to the jurisdiction thereof, are citizens of the United States and of the State wherein they reside. No State shall make or enforce any law which shall abridge the privileges or immunities of citizens of the United States; nor shall any State deprive any person of life, liberty, or property, without due process of law; nor deny to any person within its jurisdiction the equal protection of the laws."

Title 42 U.S.C. § 1988:

> "The jurisdiction in civil and criminal matters conferred on the district courts by the provisions of this chapter and Title 18, for the protection of all persons in the United States in their civil rights, and for their vindication, shall be exercised and enforced in con-

> formity with the laws of the United States, so far as such laws are suitable to carry the same into effect; but in all cases where they are not adapted to the object, or are deficient in the provisions necessary to furnish suitable remedies and punish offenses against law, the common law, as modified and changed by the constitution and statutes of the State wherein the court having jurisdiction of such civil or criminal cause is held, so far as the same is not inconsistent with the Constitution and laws of the United States, shall be extended to and govern the said courts in the trial and disposition of the cause, and, if it is of a criminal nature, in the infliction of punishment on the party found guilty. In any action or proceeding to enforce a provision of sections 1981, 1982, 1983, 1985, and 1986 of this title, title IX of Public Law 92-318, or in any civil action or proceeding, by or on behalf of the United States of America, to enforce, or charging a violation of, a provision of the United States Internal Revenue Code, or title VI of the Civil Rights Act of 1964, the court, in its discretion, may allow the prevailing party, other than the United States, a reasonable attorney's fee as part of the costs."

Missouri Revised Statutes, § 188.025:

> "Every abortion performed subsequent to the first twelve weeks of pregnancy shall be performed in a hospital."

Missouri Revised Statutes, § 188.030.3:

> "An abortion of a viable unborn child shall be performed or induced only where there is in attendance a physician other than the physician performing or adducing the abortion who shall take control of and provide immediate medical care for a child born as

> a result of the abortion. During the performance of the abortion, the physician performing it, and subsequent to the abortion, the physician required by this section to be in attendance, shall take all reasonable steps in keeping with good medical practice, consistent with the procedure used, to preserve the life and health of the viable unborn child; provided that it does not pose an increased risk to the life or health of the woman."

Missouri Revised Statutes, § 188.047:

> "A representative sample of tissue removed at the time of abortion shall be submitted to board eligible or certified pathologist, who shall file a copy of the tissue report with the state division of health, and who shall provide a copy of the report to the abortion facility or hospital in which the abortion was performed or induced and the pathologist's report shall be made a part of the patient's permanent record."

STATEMENT OF THE CASE

On June 29, 1979, the Governor of the State of Missouri signed into law fifteen new sections of a comprehensive statutory scheme relating generally to the subject of abortion. On June 30, 1979, the plaintiffs filed their complaint in the United States District Court for the Western District of Missouri challenging, as unconstitutional, nine of those statutes. The challenged sections included: Section 188.020, providing that only licensed physicians may perform abortions; Section 188.025, providing that abortions after twelve weeks gestation must be performed in hospitals; Section 188.028, regulating abortion services for minors, and providing for parental or judicial consent; Section 188.030, regulating abortions after viability; Section 188.039, providing for informed consent to abortions, including the requirement that certain facts be related by attending physicians to their abortion clients; Section 188.047, requiring a pathology report after every abortion; Section 188.052, providing for the collection and submission of abortion and complication reports for statistical purposes; Section 188.063, regulating abortion counseling; and Section 188.075, providing criminal penalties for violations of abortion statutes. Ultimately, the plaintiffs did not pursue their challenge to Section 188.075.

A trial was conducted in the District Court from October 15 to October 20, 1979. Numerous expert witnesses testified in support of or in opposition to the statutes under challenge. A representative sample of the opinions adduced from the experts testifying during the original trial of this case has been reproduced at pages 95 through 157 of the Joint Appendix. Where appropriate in the argument portion of this brief, we have set forth references to the factual record which relate to the specific statutes presently before the Court for review. Generally, experts testifying on behalf of plaintiffs testified that abortions performed by means of the dilatation and evacuation procedure, especially in the early stages of the second trimester, could be performed as safely and less expensively in clinics as in hospitals. Experts for the defendants testified that all second trimester abortions should be performed in hospitals because of the increased risks of morbidity and mortality as pregnancy progresses, and because hospital facilities include better means with which to diagnose and treat the common complications of second trimester abortions. The evidence demonstrated that there exists conflicting opinions within the medical profession as to the safety of performing dilatation and exacuation abortions, early in the second trimester, in well-staffed professional abortion clinics. However, there was unanimity of opinion that those approximately 50% of second trimester abortions performed by other procedures, primarily by installation of saline or prostaglandins, should always be done in hospitals (Cross-Pet.App. A at A-7 n.8) (A 54-55). Additionally, experts for the plaintiffs testified that submission of tissue samples from abortions for pathology reports in every instance is unjustified because the attending physician should use his discretion in that regard and because pathologists cost extra money. Experts for the defendants testified that a pathology report should be done for every abortion because of the potentially dangerous medical conditions which can be properly diagnosed only if a trained pathologist studies surgical tissue samples. Experts for the plaintiffs also testified that a second physician was unnecessary during a late pregnancy abortion, if dilatation and exacuation were the procedure used, because a child cannot survive such a procedure, although only one of the plaintiffs' experts was wiling to testify that dilatation and evacuation should be used after viability (A 130). Several of plaintiffs' experts testified that it was not good medical practice to perform a dilatation and exacuation after viability (A 114, 129-130). There was also testimony by experts for the plaintiffs that a second physician was necessary to protect the life of a child born alive as a result of an abortion (A 115). The experts for the defendants uniformly supported the proposition that a second physician should be in attendance during a post-viability abortion.

The District Court entered its primary opinion and order on January 23, 1980 (Cross-Pet.App. A at A-1-53). The District Court declared Sections 188.025, second trimester hospitalization, 188.028, parental or judicial consent for the abortion of minors, 188.030, proscribing abortions after viability, requiring a procedure of abortion be used which would most protect the chances of the fetus to survive, unless that procedure was more dangerous to the mother than some other available procedure, and requiring the attendance of a second physician at a post-viability abortion, and 188.063, regulating abortion counseling, unconstitutional in their entirety. The District Court also found that portions of Section 188.039, involving informed consent and the information to be provided the prospective abortion client, to be unconstitutional, upholding the remaining portions of that statute. The trial court upheld Sections 188.020, providing that only licensed physicians may perform abortions, 188.047, respecting pathology reports, and 188.052, statistical reporting requirements, as written.

The District Court awarded $22,037.73 in attorneys' fees and costs, including specifically $19,279.00 in attorneys' fees (A 7-8). The trial court awarded attorneys' fees for every hour claimed by the attorneys for the plaintiffs (A 4-6). Not one single hour of the time claimed by the attorneys for the plaintiffs was discounted by the District Court.

The Court of Appeals filed its interlocutory opinion and order on July 8, 1981 (Cross-Pet.App. B at A-54-112). In its interlocutory opinion, the Court of Appeals reversed the District Court with respect to Section 188.028, in effect upholding the requirement that a minor secure parental or judicial consent to an abortion, and on two-thirds of Section 188.030, finding in favor of the defendants with respect to two of the three sections included in the statute regulating abortions after viability. The appeals court also reversed on Section 188.047, in effect invalidating the pathology requirement. The remainder of the District Court opinion was affirmed except that the case was remanded for further proceedings and findings relating to the second trimester hospitalization requirement and to the reporting of abortions and abortion complications.

On remand, additional evidentiary proceedings were conducted before the trial court on August 6 and 7, 1981 (A 157, 187), and the opinion of the District Court on remand was filed on October 2, 1981 (A 9-23). The District Court reaffirmed its legal conclusion that Missouri's second trimester hospitalization requirement was unconstitutional. The trial court also stood by its position that Missouri could constitutionally require the reporting of all abortions and abortion complications. On remand, the deposition of Dr. Willard Cates, Chief of Abortion Surveillance for the National Centers for Disease Control, was taken including exhibits. His testimony and exhibits represent the latest statistical evidence on the medical risks of abortion and is referred to on several occasions during the ARGUMENT portion of this brief. A table illustrating death-to-case rates for legal abortions from 1972-1978 is demonstrative (A 92):

Table 20
Death-to-Case Rate for Legal Abortions,
by Weeks of Gestation, United States, 1972-1978

Weeks of Gestation	Deaths[1]	Abortions[2]	Rate[3]	Relative Risk[4]
≤ 8	13	2,749,725	0.5	1.0
9-10	24	1,705,478	1.4	2.8
11-12	20	883,932	2.3	4.6
13-15	20	300,186	6.7	13.4
16-20	47	338,488	13.9	27.8
≥ 21	12	68,584	17.5	35.0
Total	136	6,046,393	2.2	

[1] Excludes deaths from ectopic pregnancy

[2] Based on distribution of 4,292,615 abortions (71.0%) with weeks of gestation known

[3] Deaths per 100,000 abortions

[4] Based on index rate for ≤8 menstrual weeks' gestation of 0.5 per 100,000 abortions

The supplemental and final opinion of the Eighth Circuit, incorporating its conclusions as set forth in the interlocutory opinion of July 8, 1981, and affirming the District Court with respect to the sections remanded for further proceedings, was entered on November 30, 1981 (Cross-Pet.App. C at A-113-121).

This Court has granted plaintiffs' petition for a writ of certiorari to review the action of the United States Court of Appeals for the Eighth Circuit in upholding Section 188.028, regulating abortion services for minors. Because of the briefing schedule agreed to by the parties, and concurred in by the Clerk of this Court, the opening brief of the plaintiffs will be addressed solely to the issue which they successfully sought to have reviewed. The defendants will address Section 188.028 in their responsive brief. In this, their opening brief on the merits, the defendants present their positions with respect to the action of the Eighth Circuit in invalidating a state requirement that second trimester abortions be performed in hospitals, Section 188.025, in invalidating a state requirement that tissue samples from all abortions be submitted for pathological examination, Section 188.047, in invalidating the requirement under Missouri law that a second physician be in attendance at the abortion of a viable fetus, Section 188.030.3, and the action of the Court of Appeals in affirming an award of attorneys' fees to plaintiffs for all hours expended by only partially successful attorneys. The four questions presented, as included in this brief, have been accepted for review by certiorari by the Court.

The basis for federal jurisdiction in the District Court was Title 28 U.S.C. § 1343(3) and Title 42 U.S.C. § 1983.

SUMMARY OF ARGUMENT

I. The defendants seek reversal of the United States Court of Appeals for the Eighth Circuit with respect to the invalidation of Section 188.025, Missouri Revised Statutes, requiring second trimester abortions to be performed in hospitals, of Section 188.047, requiring a pathology tissue report for all abortions, and Sections 188.030.3, requiring a second physician in attendance at abortions after viability to provide medical care to infants born as a result of the procedures. The defendants also request a remand of the case to the District Court for entry of an award of attorneys' fees which accurately reflects the limited nature of plaintiffs' success.

Only Section 188.047, requiring pathology reports, applies to first trimester abortions. The Court should reassert the principle it first announced in 1973 that the state interests is maternal health and potential life become compelling at the ends of the first and second trimesters. *Roe* v. *Wade*, 410 U.S. 113, 162-164 (1973); *Doe* v. *Bolton*, 410 U.S. 179, 194-195 (1973). The Missouri requirement that abortions after the first twelve weeks of gestation be performed in hospitals is specifically sanctioned by the language of this Court in *Roe* v. *Wade, supra,* 410 U.S. at 163-164, and, after viability, the compelling interest of the State in potential human life is paramount, authorizing the proscription of abortions not necessary to maternal life and health, and justifying the imposition of regulations on the effectuation of abortions. *Roe* v. *Wade, id; Beal* v. *Doe,* 432 U.S. 438, 445-446 (1977).

The standards announced by the Court after *Roe* and *Doe* have primarily concerned the regulation of abortion during the first trimester. The following inquiries are pertinent to the review of abortion regulation:

(1) Does the regulation impinge upon the woman's decision to abort? If not, is the regulation rationally related to a legitimate state interest?

(2) If the regulation does impinge, does it "unduly burden" the right to abortion? (The regulation may even be unduly burdensome if there is a compelling state interest).

(3) Is the degree of different treatment of abortion as compared to other surgical procedures justified by opposing state concerns and the fact that abortion involves the termination of potential life? *Carey* v. *Population Services International,* 431 U.S. 678 (1977); *Bellotti* v. *Baird,* 428 U.S. 132 (1976); and *Planned Parenthood of Central Missouri* v. *Danforth,* 428 U.S. 52 (1976).

The pathology requirement, which applies to the first trimester, passes these tests. So, too, do the hospitalization and second physician requirements even though the latter are entitled to relaxed judicial scrutiny because they apply only to the second trimester and viability respectively.

II. *Roe* v. *Wade,* 410 U.S. 113, 163-164 (1973), specifically allowed the states, during the second trimester, to regulate with respect to the facilities in which abortions were to be performed. In *Gary-Northwest Indiana Women's Services, Inc.* v. *Bowen,* 496 F.Supp. 894 (N.D. Ind. 1980), *aff'd sub. nom., Gary-Northwest Indiana Women's Services, Inc.* v. *Orr,* 451 U.S. 931 (1981), this Court had the opportunity to retreat from that bright line conferring the authority to regulate in the second trimester, but declined to do so. The requirement of hospitalization in the second trimester no less fosters the state interest in maternal health now than such a requirement did in 1973.

There does exist conflicting opinions within the medical profession as to whether early second trimester abortions, in approximately the thirteenth to fifteenth weeks of pregnancy, may be performed safely, if the dilatation and evacuation method is used, in well-staffed professional abortion clinics. There is no evidence to support the conclusion that such procedures are safer than similar operations performed in hospitals, and a substantial number of the medical profession condemn such practice. And, almost 50% of all second trimester abortions are performed by procedures other than D&E. There is absolute unanimity that all such abortions should be performed in hospitals. Even for dilatation and evacuation, procedures after fifteen or sixteen weeks are as dangerous to the health of pregnant women as the other procedures available, and D&E procedures early in the second trimester are almost three times as dangerous to life as late first trimester procedures. Abortion clinics lack the facilities, including blood banks, intensive care units, wide ranges of medication and diversified professionals, available in hospitals for the treatment of abortion complications.

The Missouri legislature acted reasonably in determining that second trimester hospitalization would promote maternal health. Accepting the factual inferences most favorable to plaintiffs, the vast majority of such procedures should always be performed in hospitals, and the medical community disagrees about the remainder. The State, enacting a regulation strictly within the parameters of applicable Supreme Court precedent, should not be required to modify its position each time an abortion-providing plaintiff alleges an improvement in abortion technique. To hold otherwise would require the ever-continuing constitutional relitigation of standards reasonably designed to protect maternal health. *Gary-Northwest Indiana Women's Services, Inc.* v. *Bowen*, 496 F.Supp. 894, 901-902 (N.D.Ind. 1980), *aff'd sub. nom.*, 451 U.S. 93

(1981); *Akron Center for Reproductive Health, Inc.* v. *City of Akron,* 651 F.2d 1198 (6th Cir. 1981).

III. Evidence adduced in the trial court indicated that the Missouri requirement of pathology reports for all abortions would increase the cost of each such procedures from $10.00 to $40.00. This cost does not represent any undue burden on the abortion process. *Wynn* v. *Scott,* 449 F.Supp. 1302, 1322 (N.D.Ill. 1978), *aff'd,* 559 F.2d 193 (7th Cir. 1979). The court below recognized that pathology reports are useful and even necessary in some cases, that pathologists can play an important role in preserving maternal health, that such reports may warn of serious, possibly fatal disorders, and that pathologists may discover something in close care which is out of the ordinary and would not be noticed by an ordinary physician. It nevertheless invalidated the relevant statute, reversing the District Court.

Missouri does not require by statute pathology reports in other types of surgical procedures. However, not all distinctions between abortions and other procedures are invalid. *Bellotti* v. *Baird,* 428 U.S. 132, 147 (1976). The statute, on its face, promotes good medical standards and maternal health. *Connecticut* v. *Menillo,* 423 U.S. 9 (1975). Missouri is justified in singling out abortions because it is the one surgical procedure commonly performed outside of hospitals by clinics which will be unlikely to complicate their procedures or refer cases to pathology absent state regulation. In addition, abortion is a procedure which affects the reproductive capabilities of patients and there have not been sufficient studies to determine the long range complications of abortions. Recorded pathology reports, in concert with abortion complication reports, should provide a statistical basis on which to study those complications.

IV. The "compelling" point in time with respect to the State's interest in potential human life is at viability, when the fetus is capable of surviving independently outside of the womb. *Roe* v. *Wade,* 410 U.S. 113, 163-164 (1973). After that point, the State may choose to impose even unduly burdensome regulations. *Beal* v. *Doe,* 432 U.S. 438, 446 (1977). Missouri's requirement that a second physician attend the abortion of a viable fetus, to provide medical care for the live-born, rationally promotes that compelling interest.

The concern of the abortionist is not, generally, with the health and well-being of the products of his surgery. Missouri is entitled to legislate for the protection of that second, state-recognized life.

The use of dilatation and evacuation procedures, after viability does indeed ensure a dead fetus. However, the use of that procedure does not constitute, except in the most rare and extreme circumstances, sound medical practice. Even if health concerns for the mother should unfortunately, in an isolated case, dictate D&E after viability, a second doctor will be able to scrutinize the choice of a procedure which always results in the death of an infant, enabling Missouri to enforce its law that a procedure of safety for the unborn be used unless more dangerous to the health of the mother.

Evidence that D&E should ever be used after viability was sparce and unconvincing, dependent solely on the testimony of one expert, who also believes his patients are always entitled to a dead fetus. To invalidate the second doctor requirement on that basis would render meaningless the past elucidations by this Court on the ability of the State to regulate abortions after viability. The vast majority of such procedures will not depend on the use of D&E, and the child will have a chance to survive. In the rare exception, the second physician will assure that D&E really is the procedure of safety to the mother, not just an excuse to avoid live birth.

V. The cross-petitioners, defendants below in the trial court, recommend the adoption of the principle that an award of attorneys' fees, under Title 42 U.S.C. § 1988, should be proportioned to accurately reflect the extent to which a plaintiff has prevailed on his substantive claims. This exact issue has been accepted for review by certiorari in *Hensley, et al.* v. *Eckerhart, et al.*, No. 81-1244, to be argued during the October, 1982, Term.

The majority of the circuits have adopted a proportionality approach. For example, *Copeland* v. *Marshall*, 641 F.2d 880, 892 (D.C.Cir. 1980); *Hughes* v. *Repko*, 578 F.2d 483 (3rd Cir. 1978); *Muscare* v. *Quinn*, 614 F.2d 577 (7th Cir. 1980); and *Nadeau* v. *Helgemoe*, 581 F.2d 275 (1st Cir. 1978). The minority position, as stated by the Eighth Circuit in this case, should be rejected.

In this case, fees were awarded for every hour claimed by plaintiffs' attorneys, although plaintiffs prevailed, numerically, on approximately 50% of their challenges against eight separate statutory sections. Public policy considerations gravitate against substantial awards of attorneys' fees against defendants who have successfully defended the constitutionality of state law. If the terms "discretion," "reasonable," and "prevailing" used in § 1988 are to have any meaning, the principle must be accepted that a plaintiff will not automatically be reimbursed for all attorney hours, once any substantive claim is successful, that it is unreasonable to reward plaintiffs and penalize defendants when state regulations are upheld, and that a plaintiff must prevail on a constitutional claim against a statute before fees will be awarded for the time spent unsuccessfully challenging it.

ARGUMENT

The Court has granted certiorari to review five questions presented by the petition and cross-petition for certiorari filed by the parties to this case. The plaintiffs sought and were granted review by certiorari with respect to the action of the United States Court of Appeals for the Eighth Circuit in upholding Sections 188.028.1 and 188.028.2(1), (3), (4), (5) and (6) of the Missouri Revised Statutes relating to parental and judicial consent for abortions preformed on minors. The Supreme Court number relating to the petition is 81-1255. The plaintiffs will address this question in their opening brief to which these defendants will respond. The argument in this the defendants' opening brief on the merits will be limited to the four questions presented in the cross-petition, which the Court has accepted for review by certiorari and assigned No. 81-1623. Therefore, this initial brief on the merits will deal with four separate questions accepted by the Court for review; (1) whether Missouri may require second trimester abortions to be performed in hospitals, (2) whether a state may require that pathology reports be prepared for all abortions, (3) whether Missouri may require the attendance of a second physician during the abortion of a viable fetus, and (4) whether an award of attorneys' fees should relate to the extent to which a plaintiff has prevailed.

It has now been approximately ten years since this Court announced its historic decisions in *Roe* v. *Wade*, 410 U.S. 113 (1973) and *Doe* v. *Bolton*, 410 U.S. 179 (1973). The decisions of the Court in *Roe* and *Doe* established certain fundamental principles around which all subsequent abortion-related cases have revolved. The fundamental right of privacy includes the abortion decision. *Roe, supra*, 410 U.S. at 153-156. Even so, no woman has a right to an abortion "at whatever time, in whatever way and for whatever reason she alone chooses . . ."; "there is no right to abortion on demand." *Roe, supra,* 410 U.S. at 153; *Doe, supra,* 410 U.S. at 189. The State interest in protecting the health of pregnant women and the separate interest in protecting potential human life become compelling at certain points in the pregnancy term (at the end of the first and second trimesters, respectively), then and there affording the state the opportunity to reasonably regulate the abortion procedure. *Roe, supra,* 410 U.S. at 162-164; *Doe, supra,* 410 U.S. at 194-195. The State regulation must be reasonably and legitimately related to recognized state interests. *Roe, supra,* 410 U.S. at 162-166; *Doe, supra,* 410 U.S. at 194-195. Prior to the compelling points, during the first trimester of the pregnancy term, the abortion decision and its effectuation is "inherently, and primarily a medical decision, and basic responsibility for it must rest with the physician." *Roe, supra,* 410 U.S. at 166.

As should be expected from the announcement of a radical change in constitutional law, *Roe* and *Doe* did not put to rest the matter of abortion as an issue to be litigated in the federal courts. In the intervening years, a substantial body of Supreme Court and federal appellate court precedent, of an abortion specific nature, has been published. The defendants, the Attorney General for the State of Missouri and the Prosecuting Attorney of Jackson County, Missouri, respectfully submit that the legislative scheme adopted by the Missouri General Assembly, and made effective by gubernatorial signature on June 29, 1979, was written specifically in response to guidelines established by United States Supreme Court precedent. Especially with respect to the specific statutory sections to be reviewed by this Court, the legislation was drafted to protect the important and judicially recognized state interests in maternal health, maintenance of good medical standards, potential human life, childbirth, and the sanctity of the family. On the authority of Supreme Court case law, the Missouri statutory sections now to be reviewed were promulgated. On the authority of that same judicial precedent, these Missouri statutory sections must now be upheld.

The introductory portion of the argument in this opening brief on the merits includes a review of the judicial standards to be applied to abortion-related legislation. In Point I of this brief, we shall show that the reasons which lead this Court to conclude in *Roe* v. *Wade* that state regulation after the first trimester may include limitation with respect to the facility in which the abortion is to be performed are still valid,[1] and that the Missouri statute requiring abortions subsequent to the first twelve weeks of pregnancy to be performed in hospitals is reasonably related to the compelling governmental interest in protecting maternal health. In Point II we shall show that the requirement of pathology reports following all abortions, even though that requirement applies to first trimester abortions, does not unduly burden the right of a woman to an abortion and is justified to protect maternal health and to maintain sound medical standards. In Point III we submit that the "compelling" point with regard to Missouri's important and legitimate interest in potential human life remains at the time of viability,[2] and that requiring the attendance of a second physician during the abortion of a viable unborn child is reasonably designed to protect the interests of the state at that "compelling" point in time. Point IV proposes that awards of attorneys' fee should reasonably relate to the extent to which plaintiffs can be deemed to have prescribed.

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[1] *Roe* v. *Wade*, 410 U.S. 113, 163-164, *reh. den.*, 410 U.S. 959 (1973).

[2] The Court made the following statement in *Roe* v. *Wade*, 410 U.S. 113, 163-164 (1973):

(Continued on next page)

Introduction:

The Standards to be Applied in the Review of Abortion-Related State Legislation

Of the Missouri statutory sections discussed in this brief, only Section 188.047, requiring pathology reports for all abortions, applies to abortions performed in the first trimester. Early lower federal court cases, overreacting to the decisions of this Court in *Roe* and *Doe*, held that absolutely no regulation of the abortion decision or its effectuation in the first trimester was constitutional.[3] The Supreme Court, however, in *Planned Parenthood of Central Missouri* v. *Danforth*, 428 U.S. 52 (1976), reversed this trend by holding that not all abortion regulations that apply to the first trimester are unconstitutional, and that regulations dealing with abortions are not unconstitutional merely because the state does not impose similar burdens on other medical procedures. See also, *Wynn* v. *Scott*, 449 F.Supp. 1302 (N.D.Ill. 1978). Abortion, unlike other medical procedures, involves the termination of potential life. *Maher* v. *Roe*, 432 U.S. 464 (1977). While this Court has recognized a constitutionally protected interest in making

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Footnote continued

"Wth respect to the State's important and legitimate interest in potential life, the 'compelling' point is at viability. This is so because the fetus then presumably has the capability of meaningful life outside the mother's womb. State regulation protective of fetal life after viability thus has both logical and biological justifications. If the State is interested in protecting fetal life after viability, it may go so far as to proscribe abortion during that period, except when it is necessary to preserve the life or health of the mother."

[3] See *Arnold* v. *Sendak*, 416 F.Supp. 22 (S.D.Ind. 1976), *aff'd*, 429 U.S. 968 (1976); *Poe* v. *Gerstein*, 517 F.2d 787 (5th Cir. 1975), *aff'd*, 428 U.S. 901 (1976); *Friendship Medical Center, Ltd.* v. *Chicago Board of Health*, 505 F.2d 1141 (7th Cir. 1974), *cert. den.*, 420 U.S. 997 (1975); *Word* v. *Poelker*, 495 F.2d 1349 (8th Cir. 1974); *Doe* v. *Zimmerman*, 405 F.Supp. 534 (N.D.Pa. 1975); *Hallmark Clinic* v. *North Carolina Department of Human Resources*, 380 F.Supp. 1153 (E.D.N.C. 1974); *Doe* v. *Rampton*, 366 F.Supp. 189 (D.Utah 1973).

certain kinds of important decisions free from governmental compulsion, *Whalen* v. *Roe,* 429 U.S. 589 (1977), such decisions are not absolute. *Carey* v. *Population Services International,* 431 U.S. 678 (1977).

> "As Whalen makes clear, the right in Roe v Wade can be understood only by considering both the woman's interest and the nature of the State's interference with it. Roe did not declare an unqualified 'constitutional right to an abortion,' . . . Rather, the right protects the woman from unduly burdensome interference with her freedom to decide whether to terminate her pregnancy. . . ." *Maher* v. *Roe, supra,* 432 U.S. at 473-474.

In adidtion, "not all distinction between abortion and other procedures is forbidden." *Bellotti* v. *Baird*, 428 U.S. 132, 145 (1976). The constitutionality of such distinction will depend upon the degree and the justification for it.

Three tests have been established by this Court to determine whether or not abortion regulations are constitutional. These tests, because of the context in which cases have been presented to this Court, relate primarily to the regulation of abortion by states in the first trimester. However, we believe the standards are of assistance in evaluating all abortion specific legislation. First, does the regulation impinge upon the abortion decision. Where the obstacle does not impinge upon the woman's freedom to make a constitutionally protected decision, or if it merely makes the physician's work more laborious or less independent, *Whalen, supra,* 429 U.S. at 604, the regulation is evaluated under a relaxed standard of scrutiny and the state is afforded broader power to encourage actions thought to be in the public interest. These regulations are subject to the less demanding test of rationality, *Maher, supra,* 432 U.S. at 470, and thus usually found constitutional.

Second, if the regulation does impinge upon the abortion decision, the Court must find as a matter of fact that the regulation burdens an individual's right to seek an abortion. Every regulation, however, is not unconstitutional under this test. "[T]he constitutionality protected right extends to an individual's liberty to make choices . . . [it] does not, however, automatically invalidate every state regulation in this area." *Carey* v. *Population Services International*, *supra*, 431 U.S. at 685-686. Thus, "a requirement for a lawful abortion" is not unconstitutional unless it *unduly burdens* the right to seek an abortion. *Bellotti* v. *Baird*, *supra*, 428 U.S. at 147. "[E]ven a burdensome regulation [however] may be validated by a sufficiently compelling state interest." *Carey* v. *Population Services International*, *supra*, 431 U.S. at 686. To determine if the woman's due process rights are violated, therefore, the Court must find as a matter of fact that the regulation *unduly burdens* the abortion decision *and* is not supported by a compelling state interest. If it is not unduly burdensome, the provisions need only be reasonably related to a rational state interest.

The third test is whether or not the abortion regulation makes an unconstitutional distinction between the abortion decision and other comparable surgical procedures such that it would violate equal protection of the law. However, "not all distinctions between abortion and other procedures is forbidden . . . the constitutionality of such distinction will depend upon its degree and the justification for it." *Maher* v. *Roe*, *supra*, 432 U.S. at 473; *Bellotti* v. *Baird*, *supra*, 428 U.S. at 149-150. Thus, the Supreme Court has upheld several abortion specific regulations as applied to even the first trimester. See *State of Connecticut* v. *Menillo*, 423 U.S. 9 (1975), upholding the requirement that an abortion must be performed by a physician; *Planned Parenthood of Central Missouri* v. *Danforth*, *supra*, upholding informed consent, recordkeeping and reporting requirements; and *Bellotti* v. *Baird,* 443 U.S. 622 (1979)[4] suggesting that a form of parental and court consent before a minor may obtain an abortion is constitutional.

We most assuredly do not advocate a retreat by the Court from its language in *Roe* v. *Wade* respecting the permissibility of state regulation during the second trimester, especially as it applies to the designation of the facility in which an abortion procedure may be performed, and the compelling nature of viability as that point in pregnancy where the state may go so far as to prescribe abortion altogether. *Roe* v. *Wade, supra,* 410 U.S. at 163-164. In enacting a second trimester hospitalization requirement and a requirement that a second physician be in attendance at the abortion of a viable fetus, Missouri has acted precisely within the parameters of *Roe* v. *Wade*. This Court has not by judicial opinion limited or altered its stance with respect to state regulation in the second trimester and the interest of the state in potential life after viabiliy in the intervening years since 1973. Therefore, defendants submit that the standards discussed in this section of the brief need not be applied to the afore-mentioned statutory requirements and the burden upon the state is substantially less than would be the case did those sections involve regulation of abortion in the first trimester. Nevertheless, we respectfully submit that were Sections 188.025, requiring abortions after the first trimester to be performed in hospitals, and Section 188.030.3, requiring the attendance of a second physician at the abortion of a viable unborn child, subjected to the more stringent standards established by this Court with respect to the review of abortion legislation generally, these sections should be upheld. In addition, the standards established by later Supreme Court precedent are of assistance in evaluating and reviewing all abortion specific legislation regardless of the point in pregnancy to which the regulation applies.

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[4] To this point most references to *Bellotti* v. *Baird* have been to the case popularly known at *Bellotti I,* reported at 428 U.S. 132. Both *Bellotti I* and *Bellotti II,* cited here, related to abortions for minors.

To summarize, after the first trimester of pregnancy, the state may regulate the abortion procedure in a manner reasonably related to maternal health, and is allowed to require abortions after the first trimester be performed in hospitals. *Roe* v. *Wade*, 410 U.S. at 163-164. At viability, the state's interest in potential human life is sufficiently "compelling" so as to allow the state to either proscribe abortion altogether, or to, as in the present case, legislate for the protection of the unborn child. Standards for the review of abortion legislation announced by the Court since *Roe* and *Doe* primarily relate to the regulation of abortion during the first trimester, which only the Missouri statute requiring pathology reports, of those sections discussed in this brief, specifically applies. However, those standards are of assistance in evaluating post-first trimester abortion regulation, and all the Missouri abortion statutes presently under review are valid under Supreme Court analysis. That analysis includes the following inquiries:

(1) Does the regulation impinge upon the woman's decision to abort? If not, is the regulation rationally related to a legitimate state interest?

(2) If the regulation does impinge upon the woman's decision to abort, then does it "unduly burden" her right to abortion? (Note that the regulation may even be "unduly burdensome" if there exists a compelling state interest).

(3) Is the degree of different treatment of abortion over other comparable surgical procedures justified by the difference between abortion as involving the termination of potential human life and other comparable surgical procedures?

I.

The Missouri statutory requirement that abortions sugsequent to the first twelve weeks of pregnancy be performed in hospitals is reasonably related to the state's compelling interest in preserving and protecting maternal health and is consistent with sound public policy.

In its landmark 1973 abortion decisions, this Court specifically conferred upon the states regulatory power to protect the health of abortion clients after the first trimester, or twelve weeks, of pregnancy;

> "With respect to the State's important and legitimate interest in the health of the mother, the 'compelling' point, in the light of present medical knowledge, is at approximately the end of the first trimester. This is so because of the now-established medical fact, . . . that until the end of the first trimester mortality in abortion may be less than mortality in normal childbirth. It follows that, from and after this point, a State may regulate the abortion procedure to the extent that the regulation reasonably relates to the preservation and protection of maternal health. *Examples of permissible state regulation in this area are requirements* as to the qualifications of the person who is to perform the abortion; as to the licensure of that person; *as to the facility in which the procedure is to be performed, that is, whether it must be a hospital or may be a clinic or some other place of less-than-hospital status;* as to the licensing of the facility; and the like.
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> . . . .
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> To summarize and to repeat:
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> . . . .
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> . . . For the stage subsequent to approximately the end of the first trimester, the State, in promoting its interest in the health of the mother, may, if it

> chooses, regulate the abortion procedure in ways that are reasonably related to maternal health." (Emphasis added). *Roe* v. *Wade*, 410 U.S. 113, 163-164, *reh. den.*, 410 U.S. 959 (1973).

In reliance upon the explicit language of this Court, Missouri first required second trimester hospitalization for abortion clients in 1974. Section 188.025, RSMo Cumm. Supp. 1975 provided:

> "No abortion performed subsequent to the first twelve weeks of pregnancy shall be performed except . . . in a hospital."

The Missouri Legislature restated the second trimester hospitalization requirement in its 1979 comprehensive statutory scheme relating to the subject of abortion. At that point in time, Section 188.025, RSMo Cumm. Supp. 1981, provided that:

> "Every abortion performed subsequent to the first twelve weeks of pregnancy shall be performed in a hospital."

It is this statutory requirement which was struck down by the Eighth Circuit and which is one of the subjects of this Supreme Court review by certiorari.

We submit that it was reasonable for the Missouri Legislature to conclude that a second trimester hospitalization requirement would promote maternal health. When all possible second trimester abortion procedures are considered, and the statute applies equally to all such procedures, it is clear that hospitalization should be required for the vast majority of such procedures, and that Section 188.025 promotes material health by so requiring. This conclusion is inescapable even should the Court interpret the totality of the evidentiary record in the light most favorable to plaintiffs.

The lower courts invalidated Missouri's second trimester hospitalization requirement on the basis that dilatation and evacuation procedures (hereinafter referred to as D&E) could be as safely performed outside of hospitals as in hospitals. Because hospital procedures are more expensive than clinic procedures, the Eighth Circuit concluded, the statutory section in question imposed a direct and undue burden on the decision to abort. It was found that Missouri's statute on second trimester abortions was not reasonably related to maternal health solely because early second trimester D&E procedures could be performed safely outside of hospitals.

The regulatory power reserved to the States, by this Court in *Roe* and *Doe*, to regulate the facilities at which abortions may be performed after the first trimester of pregnancy is as valid today as it was in 1973. In the last year for which comprehensive abortion statistics appear in the evidentiary record, 49% of all second trimester abortions were performed using procedures other than D&E, including saline installation, installation of prostaglandins, hysterotomy and hysterectomy, or combinations of installation techniques (A 54-55). As the District Court indicated, the plaintiffs concede that these 49% of all second trimester abortions performed by techniques other than D&E should be performed only in a hospital (Cross-Pet.App. A at A-7 n.8). In point of fact, the chief executive officer of plaintiff Reproductive Health Services specifically testified that all second trimester abortions performed by procedures other than D&E should be performed in hospitals (A 164-166) and that the majority of second trimester abortions should be performed in hospitals (A 166). Again, for 1978, the last year during which statistics have been compiled, 49% of all second trimester abortions were performed by procedures other than D&E (A 54-55).

Similarly, 1978 statistics for death-to-case rates for legal abortions alarmingly demonstrate the increased danger of abortion the greater the length of the pregnancy. For example, from 1972 through 1978 the abortion death-to-case ratio for abortions performed during the first eight weeks of gestation was .5 per 100,000 abortions; for abortions performed in the ninth and tenth weeks of pregnancy, the death rate was 1.4 per 100,000 abortions; for abortions performed in the eleventh and twelfth weeks of pregnancy, the death rate was 2.3 per 100,000 abortions; for abortions performed in the thirteenth, fourteenth and fifteenth weeks of pregnancy, the death rate was 6.7 per 100,000 abortions; for abortions performed in the sixteenth, seventeenth, eighteenth, nineteenth, and twentieth weeks of pregnancy, the death rate was 13.9 per 100,000 abortions; and for abortions performed in the twenty-first week of pregnancy or thereafter, the death rate was 17.5 per 100,000 abortions (A 92). Abortions performed in the first three weeks of the second trimester hold a relative risk of death 13.4 times as great as abortions performed in the first eight weeks of pregnancy; for abortions performed in weeks sixteen through twenty, the relative risk of death is 27.8 times that of abortions performed in the first eight weeks of pregnancy; and for abortions performed in the twenty-first week or thereafter, the relative risk of death to the abortion client is 35 times as great as abortions performed in the first eight weeks of pregnancy (A 92). Even abortions performed early in the second trimester are approximately three times as likely to result in maternal death as abortions performed late in the first trimester (A 92). It is those second trimester abortions performed at thirteen to fifteen weeks gestation, as figured from last menstrual period, which the Chief of Abortion Surveillance for the National Centers of Disease Control believes can be performed as safely in clinics as in hospitals if the D&E procedure is used (A 78). However, after 15 weeks, D&E is as dangerous as instillation as an abortion procedure (A 83). It must be remembered, however, that even with respect to the D&E procedures, abortions performed after fifteen weeks are considerably more dangerous to the life of the mother than D&E abortions performed very early in the second trimester (A 81, 92) and, have a greater death-to-case rate than childbirth (A 63). As discussed *infra,* under Missouri law these statistics should be applied to abortions after thirteen weeks because conception rather than last menstrual period is used as a statistical base.

Nationally, in 1978, approximately 90% of all abortions were performed in the first trimester. The same was true for the State of Missouri (A 91). Therefore the second trimester hospitalization requirement would apply to only 10% of all abortions performed in 1978. There is reason to believe that a greater percentage of abortions are being performed, as of the present time, in the first trimester than was true in 1978. It is reasonable for the State of Missouri to have singled out these 10% of abortions, or less, for hospitalization. With each two week delay in abortion, after the tenth week, there is a doubling of morbidity, both major and minor, and mortality. The Chief of Federal Abortion Surveillance, Dr. Willard Cates, has stated that it is reasonable to perform abortion procedures with death-to-case rates of approximately 10 to 100,000 or less outside of hospitals (A 86). Beyond the fifteenth week after last menstrual period, the death-to-case rate for abortions is greater than 10 per 100,000. Clearly, on the basis of plaintiffs' own statistical evidence, the vast majority of all second trimester abortions, regardless of procedure, should be performed, in the best interests of maternal health, inside of hospitals. And, regardless of plaintiffs' various factual allegations concerning the relative safety of clinic-performed early second trimester abortions, it would be reckless to invalidate a Missouri law designed to protect maternal health where there have been no controlled statistical studies of the comparative safety of D&E procedures performed in and out of hospitals (A 56).

The very most that plaintiffs proved factually is that some experts believe that early second trimester abortions, using the D&E procedure, can be performed safely outside of the confines of hospitals. The majority of second trimester abortions cannot, even if the Court should draw these factual inferences most favorable to the plaintiffs' case. Furthermore, the weeks of pregnancy, as referred to previously in this brief and in the evidence, are misleading when applied to the Missouri statutory section requiring hospitalization for second trimester abortions. Weeks of gestation as computed by the National Centers of Disease Control, for example, are computed as from the last menstrual period (A 77-78). However, there are two separate and distinct methods by which the duration of pregnancy can be measured. We respectfully submit that the first twelve weeks referred to in Section 188.025 relate to gestational periods measured from the date of conception. Conception is defined in Section 188.015(3). Section 188.025 speaks of abortions "performed subsequent to the first twelve weeks of pregnancy" which should be interpreted as being measured from conception in that pregnancy medically begins at that point of time. Section 188.039.2(2), respecting informed consent, would have required a physician to inform his patient of the "number of weeks elasped from the probable time of conception of her unborn child." The only reasonable conclusion is that the date of conception, as opposed to last menstrual period, should be used in calculating trimesters under Missouri law.

As a consequence, when Dr. Cates refers to abortions in the thirteenth, fourteenth and fifteenth weeks as being safe to perform outside of hospitals, an adjustment should be made to conform to Missouri law, meaning that reference is really being made to Missouri abortions performed in the eleventh, twelfth and thirteenth weeks of pregnancy (A 78). Therefore, Section 188.025 only prohibits nonhospitalized abortions, believed safe if performed by D&E by the Chiefs of Federal Abortion Surveillance, in the thirteenth week after conception. Clearly when this factual adjustment is made to account for the different method by which to measure the weeks of gestation, the Missouri statutory requirement not only promotes maternal health in the vast majority of all second trimester abortions, but would only exclude, according to Dr. Cates, only one week from the period of pregnancy allegedly safe for nonhospitalized abortions by D&E.

Dr. Cates, who believes that early second trimester D&Es can be performed safely in quality abortion clinics, is pro-choice and has been the frequent target of "pro-lifers" (A 51). He admits, and statistics clearly indicate, that "abortions performed by the D&E procedure [are] more dangerous to the health of the mother at 13 weeks or thereafter than they are at 12 weeks and before" (A 59). He also admits that it is fair to say that some authorities feel that widespread use of D&E by physicians inexperienced in this technique may increase the risk of the procedure; that second trimester D&E is so risky that it should be performed only in hospitals; and that some authorities predict that the increasing use of D&E in nonhospital facilities will cause an increase in deaths and complications (A 61). Surely, the Missouri Legislature was reasonable in concluding that second trimester abortions should be performed in hospitals for the protection of the life and health of abortion clients. The experts testifying on behalf of the defendants at trial were unanimous in their support for such a requirement as constituting sound medical practice (A 142, 151, for example, includes the opinions of Dr. Bernard Nathanson and Dr. Richard Schmidt). That the plaintiffs might be of a different opinion does not constitute proof that the statute was unreasonably enacted. From 1972 through 1978, there were 136 abortion-related deaths from the performance of legal abortions. Seventy-nine of those deaths or almost 60%, resulted from second trimester abortions, even though only 10% of all abortions were actually performed in the second trimester (A 91, 92). Health risks, other than death, also increase after the first twelve weeks of pregnancy. Hospitals are better staffed and equipped to treat the most common complications of abortion, infection and hemorrhage (A 57-58, 142, 153, 163, 184-185). Compared to doctor's offices, abortion clinics, and high school gymnasiums, among other places, hospitals have better blood typing capabilities, have blood banks, have a wider range of medicines and staff to treat infections, have intensive care wards, and are generally better equipped to deal with the serious potential medical complications of abortions.

This case, as it was presented before the lower courts, is not the first instance in which the federal courts have been confronted with evidence concerning the relative safety of early second trimester D&E abortions and the expense of hospitalization. Similar evidence was produced in *Akron Center for Reproductive Health, Inc.* v. *City of Akron*, 651 F.2d 1198 (6th Cir. 1981), and in *Gary-Northwest Indiana Women's Services, Inc.* v. *Bowen*, 496 F.Supp. 894 (N.D.Ind. 1980); *aff'd sub. nom., Gary-Northwest Indiana Women's Services, Inc.* v. *Orr*, 451 U.S. 931 (1981).

In both instances, the hospitalization requirement was upheld. With respect to evidence concerning the safety of dilatation and evacuation procedures in the early stages of the second trimester, the three-judge district court in *Gary-Northwest* stated that:

> "It would be impractical for the constitutionality of a second trimester regulation to depend on a factual question, such as whether the regulation in fact reduced maternal morbidity and mortality. Interpreting *Roe* to require that second trimester regulations except specific types of abortions which may be safer than childbirth would require relitigation of the regulation's constitutionality with each change in the avaliability of abortions, with each improvement in abortion technique, and with each publication of statistics showing that abortion skills have improved. Such an interpretation of *Roe* would result in repeated relitigation of the constitutionality of the same statute. It is the policy of the Supreme Court to avoid, if possible, the creation of rules of law which increase litigation. *Roe* should not be given an interpretation which results in repeated relitigation of a statute's constitutionality. *Roe* does not render the constitutionality of a second trimester regulations subject to either the availability of abortions or the improvements in medical techniques and skills.
>
> The test for determining the constitutionality of statutes regulating second trimester abortions is not whether the statute has the statisically demonstrably result of decreasing maternal morbidity or mortality for specific groups of abortions. Whether, as a matter of fact, it is satistically demonstrable that the regulation results in deceased maternal morbidity and mortality is a matter to be considered, but it is not the

> ultimate test. The ultimate test is a broader test: whether the legislature acted reasonably in determining that the regulation would promote maternal health. Furthermore, the statistics used to determine the reasonableness of a regulation would have to be the statistics not for a specific group of abortions, but for all the abortions to which the regulation applies. A statutory regulation of second trimester abortions is constitutional if it was reasonable for the state to conclude that the regulation would promote maternal health.
>
> It was reasonable for Indiana to conclude that the second trimester hospitalization requirement would promote maternal health." *Gary-Northwest Indiana Women's Services, Inc.* v. *Bowen, supra,* 496 F.Supp. at 901-902.

The *Gary-Northwest* district court also had an answer to the argument that the increased expense of hospitalization would place an undue burden upon the decision to abort:

> "The combination of the hospitalization requirement and the pregnant women's indigency does not render unconstitutional this pursuit of Indiana's legitimate, compelling, interest in protecting maternal health. The obstacle which the women face is not the hospitalization requirement, but the women's indigency. . . ." *Id* at 901.

This Court affirmed, without opinion the judgment of the three-judge district court in the above-reference case. As the Sixth Circuit held in upholding a second trimester hospitalization requirement for the City of Akron, Ohio:

> "Many of the same arguments for holding the requirement that all second trimester abortions be performed in a hospital unconstitutional which were made in the present case were made by the plaintiffs in *Gary-*

> *Northwest*. Though the evidence on this issue in the present case was more detailed than that produced in *Gary-Northwest*, the thrust of the plaintiffs' proof and argument was the same. The Supreme Court has now had an opportunity to retreat from the 'bright line' drawn in *Roe* v. *Wade* and has declined to do so. . . ." *Akron Center for Reproductive Health, Inc.* v. *City of Akron*, 651 F.2d 1198, 1210 (6th Cir. 1981).

This Court should continue to maintain that "bright line." There must be a point in any pregnancy where the interest of government in protecting the health of pregnant women is sufficiently compelling that regulation with respect to ensuring that safety is warranted. In pursuit of sound public policy, the Court should not interfere or invalidate state government efforts which are reasonably and rationally designed for the protection and preservation of the health of its citizens. The requirement of hospitalization will not only protect the health and life of pregnant women undergoing abortions after the first twelve weeks of pregnancy, but will in addition have the benefit of publicly emphasizing the increased risk of delaying the abortion decision. Statistics demonstrate that an increasingly large percentage of total abortions are being performed in the first trimester with each succeeding year. Publicity about the increased risks of delayed abortions, and public requirements in many states that second trimester abortions be performed in hospitals, must be considered to have a positive and beneficial influence in encouraging women to make their abortion decisions at the earliest possible stages of pregnancy (A 54). The plaintiffs assert that D&E abortions performed early in the second trimester can be performed safely outside of hospitals. The experts for the defendants strongly disagree. Whatever one's view is of this medical debate, it is clear that the vast majority of abortions, those not performed by means of dilatation and evacuation and those dilatation and evacuation abortions performed after the very early stages of the second trimester, should most definitely be done in hospitals. Plaintiff Reproductive Health Services is a professional and highly experienced abortion clinic. However, the absence of Missouri statutory Section 188.025 would do more than just allow Reproductive Health Services to perform D&E abortions two, three or four weeks later into the pregnancy term. It would also allow less experienced, smaller clinics, less experienced and more profit-minded physicians, and persons not as enamored of the D&E method as are plaintiffs to perform abortions, outside the confines of hospitals, from the thirteenth week of pregnancy up and until the date of birth. Such action would allow doctors to perform abortions in their offices or in their patients' homes. It would allow the installation of saline or prostaglandins, or the performance of hysterectomy surgery, in settings other than hospitals.

Missouri's regulation applies to all abortions after the first twelve weeks subsequent to conception. It does not just apply to D&E abortions performed at highly experienced clinics like Reproductive Health Services early in the second trimester. As was true in 1973, the requirement of second trimester hospitalization for abortions is, today, an example of reasonable and permissible state regulation in the abortion area. *Roe* v. *Wade*, 410 U.S. 113, 163, *reh. den.*, 410 U.S. 959 (1973).

II.

The Missouri statute requiring that pathology reports be prepared for all abortions is reasonably and rationally related to the State's interest in maternal health and maintenance of sound medical standards, and does not unduly burden the right to seek an abortion.

Missouri Revised Statutes, Section 188.047, provides that:

> "A representative sample of tissue removed at the time of abortion shall be submitted to a board eligible or certified pathologist, who shall file a copy of the tissue report with the state division of health, and who shall provide a copy of the report to the abortion facility or hospital in which the abortion was performed or induced and the pathologist's report shall be made a part of the patient's permanent record."

The District Court and the Court of Appeals reached entirely different conclusions respecting the validity of the Missouri staute requiring pathology reports for all abortion procedures.

The District Court concluded that the evidence was insufficient to demonstrate that the required tissue examination would unduly burden the decision to abort (Cross-Pet.App. A at A-39). In reaching his conclusion, the trial judge relied on testimony that the additional cost of pathology would range from $10.00, for a gross examination, to $40.00, in cases where multiple microscopic examinations of the tissue were necessary. Because the trial judge found that the pathology requirement was not unduly burdensome, it applied a rational basis test finding that such a requirement was reasonably related to a legitimate State interest in maintaining the standard of medical care provided abortion patients.

The Eighth Circuit reversed. The appeals court framed the issue as follows:

> "The issue here is not whether pathology reports are useful and even necessary in some cases. They clearly are. Testimony indicated that abnormalities in the tissue may warn of serious, possibly fatal disorders.

> Instead, the question here is whether Missouri has shown any reason why the physicians and medical facilities performing abortions cannot make medical judgments about the desirability of a pathology report in an individual case, while physicians and medical facilities performing all other types of surgery are free to exercise their professional judgment." (Cross-Pet.App. B at A-95).

The appeals court also accepted as true testimony indicating that a pathologist may see something in a close case which is out of the ordinary but which would not be discovered by an ordinary physician. Nevertheless, this Missouri statutory requirement was stricken on the premise that the State could not so distinguish between first trimester abortion and other surgical procedures when it required pathology reports (Cross-Pet.App. B at A-96). The appeals court cited the testimony of plaintiffs' experts, who perform abortions, that they exercise their professional judgment concerning the necessity of a pathology report. The court ignored the testimony of the most experienced of all abortion practitioners testifying, however. Dr. Bernard Nathanson required a pathological examination after each and every one of the 60,000 abortions performed under his guidance at the New York Center for Reproductive and Sexual Health, for the reason that it was in his opinion "absolutely necessary to obtain a pathologist's report on each and every specimen of tissue removed from abortion or for that matter from any other surgical procedure which involves the removal of tissue from the human body." (A 143-144).

In basing its conclusion on the fact that the State of Missouri has failed to require pathology reports in other types of surgical procedures, the Eighth Circuit failed to take into account the unique nature of the abortion procedure and of the fact that abortion is the one surgical procedure in the State of Missouri which is routinely performed outside of hospitals. Abortion is a surgical procedure which affects the reproductive capabilities of the patient. There is insufficient medical evidence, at this point in time, upon which to base a conclusion that abortion will not seriously effect subsequent pregnancies (A 72-73). In addition, the requirement of a pathological examination will ensure the detection of ectopic pregnancies, which can be fatal. The additional benefits to the woman are the opportunity for a trained pathologist to discover the presence of a molar pregnancy, a hydatritaforme mole or other precancerous growths, and a variety of other problems which can only be discovered through a pathological examination (A 147-148).

The Court of Appeals dwelt at some length upon the fact that the State did not require by statute pathology reports in other kinds of surgical procedures. However, there is no evidence on the record to demonstrate that the performance of surgery, other than abortions, is routinely being performed in this State outside of hospital settings. Further, it was not demonstrated that in-hospital surgery does not routinely result in tissue examination by a qualified pathologist. Abortion is unique with respect to the locus of the procedure. It is a surgical procedure not routinely performed in hospitals. In the present case, a qualified pathologist testified that it is never appropriate not to conduct a pathology examination on the products of a surgical procedure (A 147). Abortion clinics are not routinely monitored by government agencies, nor are their surgical employees evaluated by medical records committees, peer groups or JCAH review (A 73-74). Hospitals are. That Missouri does not require by statute pathological examinations with respect to other surgical procedures is not only rational, but to be expected. When there exists in the State of Missouri free standing clinics, like the plaintiff Reproductive Health Services, which initiate the performance of thousands of nonhospital surgical procedures each year, at that point in time it would become rational to introduce a pathology requirement respecting procedures other than abortion. However, at this point in time, abortion is the surgical procedure being performed outside of hospitals on a wide-spread basis. The requirement of pathology reports is one way in which Missouri can monitor abortion clinics and ensure that potentially serious medical problems are diagnosed and treated. Merely because of an increased cost ranging from $10 to $40,[5] Section 188.047 does not constitute an undue burden on a woman's decision to abort. A requirement for a lawful abortion is not unconstitutional unless it unduly burdens the right to seek an abortion, *Bellotti* v. *Baird,* 428 U.S. 132, 147 (1976), and not all distinctions between abortion and other procedures are invalid. In addition, the interests of the State of Missouri fostered by the subject legislation, maternal health and the maintenance of good medical standards, have been explicitedly accepted by this Court as justification for the regulation of abortion. *Roe* v. *Wade,* 410 U.S. 113 (1973); *Connecticut* v. *Menillo,* 423 U.S. 9 (1975). The minimal additional costs imposed by the pathology requirement do not, standing alone, constitute such a burden on the abortion decision as to justify invalidation. *Harris* v. *McRae,* 448 U.S. 297 (1980).

The appellate court which invalidated Section 188.047 did itself recognize that pathology reports are useful and even necessary in some cases. That court recognized the role that the pathologist can play in protecting and preserving maternal health (Cross-Pet.App. B at A-95). We submit that this Court should conclude, as the district court did in *Wynn* v. *Scott*, 449 F.Supp. 1302, 1322 (N.D.Ill. 1978), *aff'd,* 559 F.2d 193 (7th Cir. 1979) that this provision does not impose a burden on the abortion process. No other rational conclusion can follow but that Missouri has demonstrated a reasonable concern for the health of its citizens by requiring pathology reports for all abortion procedures, including first trimester abortions, in light of the unprecedent numbers of these surgical procedures which are being performed in facilities of less than hospital status. The statute does not unduly burden the abortion decision or its effectuation, and is compatible with the State's compelling interests in maternal health and sound medical standards.

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[5] The estimated cost of compliance with this statutory section for plaintiff Reproductive Health Services if $19.40 per abortion procedure (Cross-Pet.App. A at A-39 n.48).

III.

Requiring the attendance of a second physician during the abortion of a viable unborn child, other than the physician performing the abortion and whose purpose it is to provide immediate medical case to the child, as Missouri has done by statute, rationally supports the State's compelling interest in protecting potential human life.

Section 188.030.3, Missouri Revised Statutes, requires that for the abortion of a viable unborn child there shall be in attendance a second physician, other than the physician performing or inducing the abortion, who shall be responsible for providing for immediate medical care to a child born as a result of the abortion procedure. Both the trial court and the Court of Appeals found this statutory section unconstitutional on the basis that it was overbroad and imposed an undue burden on the decision to abort (Cross-Pet-App. A at A-27; Cross-Pet.App. B at A-84). The conclusion that the statute burdens the abortion decision was based upon the increased cost of a second physician during surgery. The statutes' alleged overbreadth was founded upon the conclusion that a fetus cannot survive a dilatation and evacuation procedure after viability.

The sole testimony upon which the trial and appellate courts concluded that dilatation and evacuation could be the abortion procedure of choice after viability was that of Dr. Robert Crist, an expert called to the stand by the plaintiffs (Cross-Pet.App. B at A-82). This same *expert* testified that he never has any intention of protecting the fetus after an abortion, that an abortion patient has a right not only to be rid of her pregnancy but to a dead fetus, and that as a general principle, in the case of abortion, there should never be a live fetus (A 130-131). All other expert witnesses at trial, both those called by the plaintiffs and those called by the defendants, were unanimous in their condemnation of the use of D&E late in a pregnancy after viability (See, for example, the testimony of plaintiffs' witnesses at A 117 and 129). Although Dr. Crist himself cited one example, all other expert witnesses agreed that a fetus cannot survive a dilatation and evacuation procedure (A 117, 130, 154). At a stage late enough in the pregnancy so that viability is possible, the fetus is sufficiently large that it must be dismembered, and the skull must be crushed, in order to evacuate the uterus (A 131).

The purpose of a second doctor is to provide for an immediate presence during the abortion and for immediate medical care for the child when born. Also, with a second physician present to care for the health of the second, state recognized patient, the abortionist will be careful in performing the abortion procedure that undue trauma is not inflicted upon the fetus. In light of the documentable, ideologically based, and wholesale disregard by some abortionists for the lives of the unborn, including apparently Dr. Crist upon whom the conclusions of the lower courts respecting overbreadth were based, the second doctor requirement bears a very close relationship to the compelling State interest in protecting the lives of viable unborn children.

This Court has recognized the "important and legitimate interest [of the State] . . . in protecting the potentiality of human life." *Roe* v. *Wade,* 410 U.S. 113, 162 (1973); *Beal* v. *Doe,* 432 U.S. 438, 445-446 (1977). We quote from *Roe* v. *Wade,* 410 U.S. 113, 163-164 (1973).

> "With respect to the State's important and legitimate interest in potential life, the 'compelling' point is at viability. This is so because the fetus then presumably has the capability of meaningful life outside the mother's womb. State regulation protective of fetal life after viability thus has both logical and biological justifications. If the State is interested in protecting fetal life after viability, it may go so far as to proscribe abortion during that period, except when it is necessary to preserve the life or health of the mother."

The conclusion of the lower courts that the requirement of a second physician constitutes a burden is of little or no significance under the prevailing case law. After viability, which becomes possible approximately at the beginning of the third trimester, the State can indeed chose to be burdensome in promoting its interest in potential life. In speaking to the State's interest in potential human life, this Court stated in *Beal* v. *Doe,* 432 U.S. 438, 446 (1977), that the State's interest in potential life alone does not, "at least until approximately the third trimester, become sufficiently compelling to justify unduly burdensome state interference with the woman's constitutionally protected privacy interest." Section 188.030.3 is concerned with the viable fetus. The possibility of a viable fetus begins at approximately the beginning of the third trimester. In protecting that fetus, Missouri can indeed impose a financial burden on the abortion process by requiring the attendance of a second physician who, unlike the aborting doctor, is to be concerned with the survival of the infant.

At this point during pregnancy, the State may choose to burden, even unduly, the abortion procedure.

Missouri has proscribed post-viability abortions except when necessary to preserve the health or lives of pregnant women. Second 188.030.1, Revised Statutes of Missouri. Missouri has also required that the physician performing an abortion choose the procedure most likely to preserve the life and health of the infant, except when such procedure poses a greater risk to the mother than some other available method. Section 188.030.2, Revised Statutes of Missouri. As a result, and because of the dictates of sound medical practice as substantiated by all expert witnesses testifying in the trial court other than Dr. Crist, the use of D&E for an abortion after viability is an extremely unlikely occurrence. Even for Dr. Crist, the coincidence of situations in which there are both medical indications for abortion after viability and the risk-based certified choice is dilatation and evacuation would be rare to say the least. It is important to remember that Dr. Crist never has any intention of protecting the fetus of an abortion patient (A 130). There is no statistical medical evidence to demonstrate that dilatation and evacuation is the procedure of safety after twenty-four weeks of pregnancy. Further, public policy considerations dictate that Missouri should be able to require the presence of a second physician during a third trimester abortion (that is, after viability) to scrutinize a procedure, dilatation and evacuation, which always results in the death of an infant. If there is a second physician in attendance, it must be assumed that the incidence of D&E as the procedure of choice, by a physician who believes his patient has a right to a dead fetus, will be severely reduced by the spectre of liability under Section 188.030.2, requiring a procedure of safety to the infant be used. For this Court to grant a constitutionally based immunity to a procedure which always results in the death of a viable unborn child, in the context of Section 188.030.3, creates a loophole which renders all past elucidations on the ability of a State to regulate abortions after viability meaningless.

The State does not concede that D&E should ever be the procedure of choice after viability. De believe that the invalidation by the Court of Appeals of a statutory requirement of a second physician is barbaric when based upon the tenuous assumption that a procedure which involves the dismemberment of a potential human life should be used when that life is capable of surviving outside of the womb. Nevertheless, the overbreadth conclusions of the Eighth Circuit are not convincing even if a D&E procedure after viability is accepted as possible. The Court of Appeals invalidated the statute because there is no possibility of fetal survival when D&E is used. After fifteen weeks' gestation, the risk of D&E is about the same as for other procedures (A 83), and increases dramatically thereafter (A 92). By definition, this statute applies to the fetus capable of independent life, or becoming an infant, a child, a teenager, an adult. The State is entitled to preserve and nurture that potential life. This law assists the State in doing just that. D&E is a less likely choice if there is a second physician present with medical knowledge of the individual case. In the unfortunate event that such a procedure is necessary to the life or health of the mother after viability, the State is justified in the rare exception by its compelling interest in all potential human life. If the statute specifically excepted D&E procedures, abortionists would be encouraged to use it more frequently to avoid the expense of a second physician, to ensure a dead fetus, to prevent the presence of a second professional to observe malpractice or the choice of a questionable procedure from a safety viewpoint, a fetus-destroying procedure, or to avoid their own awakening to concern for the newborn. The invalidation of this section on the basis of overbreath would be to sanction a questionable medical practice and a killing procedure.

It is clear from the language of *Roe* v. *Wade* and *Beal* v. *Doe* that State regulation of the abortion process after viability may be burdensome, even unduly so. We believe, therefore, that the expense of the second physician is irrelevant. Nevertheless, the direct imposition of the expense of a second physician is not a tax or obstacle contrived to deny a woman a medically necessary abortion, that is, the requirement of the second physician is not an "undue burden." Rather, the requirement of a second physician is to ensure that the health and well-being of the infant is appropriately taken into consideration. Further, an assumption can be made, given a sufficiently late stage in the pregnancy that viability is a factor, that the pregnant woman intended to carry the child to term were it not for unexpected medical complications. If so, the test for an "undue burden" should not be comparison with the costs of an elective abortion, but the cost of a full-term delivery, including the pediatric care attendant thereto.

The concern of the abortionist is not, generally, with the health and well-being of the products of the abortion. Missouri's requirement of a second physician when those products are capable of sustaining life outside the womb is justified and is a logical extension of the State's compelling and legitimate interest in preserving and protecting potential human life. We recognize that a preservable human life will seldom occur as a result of an abortion. Abortions should not often be performed during the third trimester and only for serious medical reasons. However, the Missouri statute is designed to enhance the probability of survival and fosters the continued development of medical expertise which will result in more children surviving at earlier gestational ages. The State may legitimately "choose to be prepared for those rare instances when there is a live birth." *Margaret S.* v. *Edwards*, 488 Supp. 181, 200 (E.D.La. 1980). In 1973, the Court authorized the states to proscribe elective abortions after viability. Missouri has chosen to do so. May it not also choose to regulate for the protection of children when a medically necessary abortion is to be performed after viability, which, by definition, refers to a stage in pregnancy when the fetus can survive, especially if there is a doctor in attendance who cares about child survival?

IV.

Attorneys' fees, awarded pursuant to Title 42 U.S.C. § 1988, should be proportioned to accurately reflect the extent to which the plaintiff has prevailed.

In *Hensley, et al.* v. *Eckerhart, et al.*, No. 18-1244, this Court has granted certiorari to review the following question:

> "Whether an award of attorneys' fees, made pursuant to Title 42 U.S.C. § 1988, should be proportioned to fairly and accurately reflect the extent to which a plaintiff has prevailed on the merits of his lawsuit in the District Court?"

The attorneys on this brief also prepared the brief for the petitioners in *Hensley* v. *Eckerhart*. The same issue is presented by the present case and has been accepted for review. Space limitations do not allow the cross-petitioners to include all of the arguments in favor of proportioning an award of attorneys' fees to accurately reflect the extent to which a plaintiff has prevailed. On that issue in this case, we ask that the Court rule in a manner consistent with the decision it reaches in *Hensley* v. *Eckerhart*, No. 81-1244.

In this case, the District Court awarded attorneys' fees for every single hour claimed by the attorneys for the plaintiff. The Eighth Circuit affirmed that award (Cross-Pet.App. B at A-98-99). In affirming the trial court award, the Court of Appeals acted inconsistently with its own award of attorneys' fees on appeal. The plaintiffs claimed 137.3 hours on appeal and requested an award of $17,162.50 (A 24-29). Without comment, the Eighth Circuit awarded only $7,500 in fees, disregarded the majority of costs claimed, and awarded only 75% of the limited remaining costs allowed (A 36-37). In their lawsuit, the plaintiffs challenged eight sections of the Missouri statutes relating to abortions.[6] Of those eight statutes challenged by the plaintiffs at the trial of this case, four were found by the District Court to be unconstitutional and one other was partially invalidated. Three of the sections were upheld by the District Court as written. Nevertheless, the appellate court approved the award of attorneys' fees by the District Court of all hours claimed by the attorneys for the plaintiffs. The Eighth Circuit did this even though their opinion on appeal further restricted the extent to which the plaintiffs succeeded in their lawsuit. For example, the Eighth Circuit reversed the District Court on the constitutionality of Section 188.028, relating to consent for minors, holding in effect for the defendants on perhaps the most important of all the statutory sections challenged in the lawsuit and the only failure which prompted the plaintiffs to seek review in this Court by certiorari. The appellate court also reversed the District Court on two-thirds of Section 188.030, relating to abortion after viability, again one of the most important statutory sections attacked in this case. On the other hand, the plaintiffs were successful before the Eighth Circuit in having the District Court's approval of the pathology report section reversed. On a numerical basis, plaintiffs were successful on almost exactly fifty percent of their claims. We do not suggest, however, that an award of fees should be an entirely mathematical exercise. Upon remand, the trial court should enjoy the flexibility to decide whether some issues, successful or not, were more important or more difficult and time-consuming to prove than others.

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[6] The plaintiffs originally challenged nine statutes but dropped their attack on Section 188.075 prior to trial.

The claims of the plaintiffs, with respect to each statutory section, were separable and distinct. Each claim could have formed the basis for a separate lawsuit alleging the unconstitutionality of one section of the Missouri law relating to abortions. Nevertheless, the Eighth Circuit reaffirmed its minority position that an award of attorneys' fees should not be limited to the hours expended on issues which were successful. The majority of lower federal courts have reached conclusions in accord with the position of the defendants on this issue.[7] Circuits which have adopted a proportionality position include the First, *Nadeau* v. *Helgemoe,* 581 F.2d 275 (1st Cir. 1978), the Third, *Hughes* v. *Repko,* 578 F.2d 483 (3rd Cir. 1978), the Fourth,

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[7] The lower federal courts have not reached a consensus on the issue of proportionality. Indeed, different panels of the same court of appeals have disagreed. *Compare, Sherkow* v. *Wisconsin,* 630 F.2d 498 (7th Cir. 1980) and *Muscare* v. *Quinn,* 614 F.2d 577 (7th Cir. 1980). A substantial number of the cases approving fees for all hours expended involve alternative legal theories as opposed to multiple claim situations. For example, see *Brown* v. *Bathke,* 588 F.2d 634 (8th Cir. 1978), the case upon which the adverse line of precedent from the Eighth Circuit is based; *Northcross* v. *Board of Education of Memphis City Schools,* 611 F.2d 624 (6th Cir. 1979), *cert. den.,* 447 U.S. 911 (1980); *Seigal* v. *Maerrick,* 619 F.2d 160 (2nd Cir. 1980); and *Lamphere* v. *Brown University,* 610 F.2d 46 (1st Cir. 1979). *Jones* v. *Diamond,* 636 F.2d 1364 (5th Cir. 1981) would be the most applicable adverse precedent in the multiple claim situation were it not for equivocal language in the opinion seemingly supporting the proposition that claimed time can be discounted if spent on nonmeritorious claims. *Id.* at 1382.

Morton v. *Charles County Board of Education*, 378 F.Supp. 394 (D.Md. 1974), *aff'd*, 520 F.2d 871 (4th Cir. 1974), the Seventh, *Batiste* v. *Furnco Construction Corporation*, 503 F.2d 447 (7th Cir. 1974), the Ninth, *Sethy* v. *Alameda County Water District*, 602 F.2d 894 (9th Cir. 1979), the Tenth, *Pearson* v. *Western Electric Installation Organization District Offices*, 542 F.2d 1150 (10th Cir. 1976), and *Gurule* v. *Wilson*, 635 F.2d 782, 794 (opinion on rehearing) (10th Cir. 1980), and the District of Columbia, *Copeland* v. *Marshall*, 641 F.2d 880, 891-892 (D.C.Cir. 1980).

We ask that this Court expressly direct that an award of attorneys' fees must be proportioned to be consistent with the extent to which a plaintiff has prevailed, and only time reasonably expended in support of successful claims should be compensated. The defendants should not be penalized by being required to pay the attorneys' fees of plaintiffs' lawyers insofar as those fees reflect time spent unsuccessfully in a constitutional attack upon state law. It is fair and logical for the defendants to reimburse plaintiffs for their successes. It is unfair and illogical to expect that the defendants should pay the plaintiffs' attorneys' fees for time spent attacking state statutes which withstood constitutional challenge. On its face, Title 42 U.S.C. § 1988 does not support such a result. Congress provided for the shifting of attorneys' fees only where a party prevailed, advised the federal courts to exercise their discretion, and instructed the judiciary to award fees which were reasonable. The plaintiffs in this case did not prevail with respect to approximately one-half of their claims. No discretion is required if, as in this case, the function of the District Court, after a plaintiff has prevailed on any one of several claims, is to automatically reimburse the plaintiffs for every hour claimed by their attorneys. It is unreasonable for the defendants to be required to reimburse plaintiffs' attorneys for the time they spent challenging statutes which were upheld.

Plaintiffs should be held responsible for maintaining records sufficient to assist courts to fashion equitable awards. *Nadeau* v. *Helgemoe,* 581 F.2d 275, 279 (1st Cir. 1978). Additionally, trial courts, after supervising discovery, taking evidence and rendering judgments, are fully capable of determining which claims, in any given lawsuit, were successful, assessing the relative importance of separate claims, and deciding the nature and extent of plaintiffs' success. Experience has demonstrated that these plaintiffs will mount a legal challenge to every state effort at regulation in the abortion context. They should not have their attorneys unjustly enriched when such a challenge fails. A purpose of Title 42 U.S.C. § 1988 is to avoid windfalls to attorneys. H.R. Rep. No. 95-1558, 94th Cong. 2d sess. 9 (1976); S. Rep. No. 94-1011, 94th Cong. 2d sess. 6 (1976). On remand, the District Court should be instructed to fashion an award which compensates plaintiffs for their successes but not for their failure. Their successes and failures should take into account the results of this Court's review.

CONCLUSION

The judgment of the Court of Appeals, insofar as it invalidated Missouri's second trimester hospitalization requirement, the requirement of a pathology report for all abortions, and the requirement that a second physician attend the abortion of any viable fetus, and insofar as that decision of the Eighth Circuit upheld an award of attorneys' fees for all hours expended by plaintiffs' attorneys, should be reversed.

Respectfully submitted,

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Respondent's Brief

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Nos. 81-1255 and 81-1623

IN THE
SUPREME COURT OF THE UNITED STATES
OCTOBER TERM, 1981

PLANNED PARENTHOOD ASSOCIATION OF
KANSAS CITY, MISSOURI, INC.,
NAIM S. KASSAR, M.D., REPRODUCTIVE HEALTH
SERVICES and ALLEN S. PALMER, D.O.,
Petitioners and Cross-Respondents,
v.
JOHN ASHCROFT, Attorney General of the State of
MISSOURI, and RALPH L. MARTIN, Prosecuting
Attorney of Jackson County, Missouri,
Cross-Petitioners and Respondents.

ON A WRIT OF CERTIORARI TO THE UNITED STATES
COURT OF APPEALS FOR THE EIGHTH CIRCUIT

BRIEF FOR THE RESPONDENTS/CROSS-PETITIONERS

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QUESTION PRESENTED FOR REVIEW[1]

1. Whether the Appellate Court erred in upholding the constitutionality of Missouri Revised Statutes, § 188.028.1 and § 188.028.2(1), (3), (4), (5), and (6), by construing the same to require a juvenile court, before it denied the petition of an unemancipated pregnant woman under 18 years of age seeking judicial consent to an abortion, to find that the minor was not emancipated and was not mature enough to make her own decision and that an abortion was not in her best interest.[2]

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[1] This responsive brief on the merits is addressed solely to the question presented for review by the petition for a writ of certiorari in Case No. 81-1255. The Court has also granted a cross-petition for certiorari, addressed to four separate and distinct questions, which petition has been assigned Case No. 81-1623 and has been consolidated with the original petition for purposes of Supreme Court review. The cross-petitioners in Case No. 81-1623 have filed their initial brief addressing the four questions presented for review in their cross-petition. This brief is in response to the initial brief filed by the petitioners in Case No. 81-1255. This brief will not address the questions presented by the cross-petition.

[2] The petitioners have completely misstated the question presented for review by the action of the Eighth Circuit in upholding the constitutionality of the Missouri statute requiring parental or judicial consent to an abortion. As presented in the petition for certiorari and in the petitioners' brief, the question is phrased in terms completely opposite to the position which the petitioners are taking in this Court. The appellate court did not construe the Missouri statute as requiring a parent or the juvenile court to approve the abortion of a minor even if the minor is found by the court to be mature enough to make her own decision. To the contrary, the appellate court construed the Missouri statute to prohibit a court from denying a petition seeking an abortion for a minor unless the court should initially find that "the minor was not emancipated and was not mature enough to make her own decision and that an abortion was not in her best interest." (Petition, Appendix B, at p. A-66.) For some inexplicable reason, the petitioners have stated the question presented for review in such a way not only as to misstate the position of the appellate court, but in a manner expressly contrary to the nature and content of their arguments.

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Nos. 81-1255 and 81-1623

IN THE
SUPREME COURT OF THE UNITED STATES
OCTOBER TERM, 1981

PLANNED PARENTHOOD ASSOCIATION OF
KANSAS CITY, MISSOURI, INC.,
NAIM S. KASSAR, M.D., REPRODUCTIVE HEALTH
SERVICES and ALLEN S. PALMER, D.O.,
Petitioners and Cross-Respondents,

v.

JOHN ASHCROFT, Attorney General of the State of
MISSOURI, and RALPH L. MARTIN, Prosecuting
Attorney of Jackson County, Missouri,
Cross-Petitioners and Respondents.

On a Writ of Certiorari to the United States
Court of Appeals for the Eighth Circuit

BRIEF FOR THE RESPONDENTS/CROSS-PETITIONERS

STATEMENT OF THE CASE

The Governor of the State of Missouri signed into law fifteen new sections of a comprehensive statutory scheme relating generally to the subject of abortion on June 29, 1979. One day thereafter, on June 30, 1979, the petitioners (hereinafter referred to as plaintiffs filed their complaint in the United States District Court for the Western District of Missouri challenging as unconstitutional nine of those statutes. A temporary restraining order was issued by the trial court on that day. Included in the sections challenged by the plaintiffs was Section 188.028, Revised Statutes of Missouri, 1981 Supplement. Section 188.028 relates to abortion services for minors, requiring in effect that an unemancipated minor under the age of 18 secure the consent of one parent or a juvenile court before abortion services are provided to her. The plaintiffs successfully sought a writ of certiorari for this Court to review the judgment of the Eighth Circuit that Section 188.028 is, except with respect to the parental notification provision, constitutional. The petition raising this issue has been assigned Case No. 81-1255. This responsive brief of the defendants is addressed solely to statutory Section 188.028 regarding the provision of abortion services to minors. The defendants also successfully sought a writ of certiorari with respect to four separate and distinct questions arising out of the opinion and order of the appellate court. Those four questions, assigned Case No. 81-1623, have already been briefed on the merits by the defendants. To repeat, this responsive brief, as was the case with the initial brief filed by the plaintiffs, concerns only the propriety of the Eighth Circuit opinion in this case as it validated, for the most part, Missouri's statutory provision respecting the provision of abortion services to minors.

The trial was conducted in the District Court from October 15 to October 20, 1979. At that point in time, the constitutionality of eight separate statutory provisions relating to abortion was in dispute. A majority of the expert witnesses called by the plaintiffs and by the defendants testified in support of or in opposition to Section 188.028. The defendants herein take the position that the testimony of experts at trial concerning this statutory section, both those experts testifying for the plaintiffs and those testifying for the defendants, is irrelevant to this Court's consideration of the constitutional validity of Section 188.028. Existing Supreme Court precedent is sufficiently specific and definite, upon the manner in which a state may and may not require parental and/or judicial consent for abortions to minors, so as to make the question presently presented solely a legal, as opposed to an evidentiary, exercise. See *Planned Parenthood of Central Missouri* v. *Danforth,* 428 U.S. 52 (1976), and *Bellotti* v. *Baird,* 443 U.S. 622 (1979) (Bellotti II). We believe that the problem before this Court is to judge whether the Missouri statute respecting abortions for minors comports with the subsantial Supreme Court precedent on identical issues already in existence. Testimony of a sociological nature concerning the nature of minors, the difficulty of the decisions confronting them, their rights, the sanctity of the family, and the importance of parental involvement in the affairs of their children have already been considered and commented upon at some length by the Court. Therefore, this statement of the case will be limited to the statute itself and the decisions of the lower courts respecting same.

Section 188.028 of the Missouri Revised Statutes prohibits any person from knowingly performing an abortion upon a pregnant woman under the age of 18 years unless:

> "(1) The attending physician has secured the informed written consent of the minor and one parent or guardian; or
>
> "(2) The minor is emancipated and the attending physician has received the informed written consent of the minor; or
>
> "(3) The minor has been granted the right to self-consent to the abortion by court order pursuant to subsection 2 of this section [subsection 2, as will be

more fully explained *infra,* details the court procedures whereby a minor may be awarded the right of self-consent to an abortion or whereby court consent may be provided for an abortion if it is in the best interest of the minor], and the attending physician has received the informed written consent of the minor; or

"(4) The minor has been granted consent to the abortion by court order, and the court has given its informed written consent in accordance of subsection 2 of this section, and the minor is having the abortion willingly, in compliance with subsection 3 of this section [subsection 3 provides that no abortion will be performed on any minor against her will unless a court should find that the abortion is necessary to save her life]."

Subsection 2 of the statute details the procedures whereby a court can grant the right of a minor to self-consent to abortion or grant its judicial consent for an abortion. The subsection provides that if a minor, or her next friend, makes an application to juvenile court for an abortion, the court shall thereafter assist her in preparing a petition setting forth certain specific information about the minor. The petition should allege that "the minor is of sound mind and has sufficient intellectual capacity to consent to the abortion . . . " or "if the court does not grant the minor majority rights for the purpose of consent to the abortion, the court should find that the abortion is in the best interest of the minor and give judicial consent to the abortion . . . ." A guardian *ad litem* is to be appointed for the child and, if she does not have private counsel, the court is to appoint counsel.

Subsection 2(2) of Section 188.028, providing the procedure whereby the parents of the minor were to be notified of the filing of the petition, was invalidated by the appellate court (Pet.App. B at A-66-69). The lower court found that notice to all parents was unconstitutional because it required mature or "best interest" minors to give notice to their parents prior to the court hearing. Therefore, Section 188.028, in the posture in which it presently appears before this Court for review contains no requirement whatsoever for parental notification, no notice before a judicial petition is filed, no notice after a judicial petition is filed, no notice that a hearing on a petition is scheduled, and no notice either before or after a court grants majority rights or finds an abortion in the best interest of a petitioning minor.

Subsection 2 of the statute goes on to require that a hearing on the merits of the petition be held as soon as possible, within five days of its filing. At the hearing, "the court shall hear evidence relating to the emotional development, maturity, intellect and understanding of the minor; the nature, possible consequences, and alternatives to the abortion; and any other evidence that the court may find useful in determining whether the minor should be granted majority rights for the purpose of consenting to the abortion or whether the abortion is in the best interests of the minor . . . ."

Subsection 2(4) outlines the permissible judicial actions on a petition for the abortion of a minor.

> "In the decree, the court shall for good cause;
>
> (a) Grant the petition for majority rights for the purpose of consenting to the abortion; or
>
> (b) Find the abortion to be in the best interests of the minor and give judicial consent to the abortion, setting forth the grounds for so finding; or
>
> (c) Deny the petition, setting forth the grounds on which the petition is denied."

If the petition is allowed, those performing the abortion are entitled to immunity against any action by the parents of the minor on the grounds of battery. The subsection provides that an appeal from an order of the juvenile court may be taken to the state court of appeals, and ensures that the appellate procedure will be sufficiently prompt. The notice of appeal is to be filed within 24 hours from the time the order is issued, the appeal is to be perfected and the record on appeal completed within five days from the date of the notice of appeal, and the state Supreme Court, "because time may be of the essence regarding the performance of the abortion, is to provide by court rule for expedited appeals." Because Section 188.028 was enjoined on the day immediately following the date upon which it was signed into law, the statute has never been in effect or in force in the State of Missouri. Therefore, understandably, as of this date, the Missouri Supreme Court has had no opportunity or need to promulgate rules respecting appeals in these cases.

The opinion of the District Court in which the consent for minors provision was addressed is reported as *Planned Parenthood Association of Kansas City, Missouri, inc., et al.,* v. *Ashcroft, et al.,* 483 F.Supp. 679 (W.D.Mo. 1980). The specific pages of the District Court Opinion relating to the constitutionality of Section 188.028 appears at Appendix A of the petition for certiorari at pages A-12 to A-17. The District Court found that the entire statute was unconstitutional. The defendants contended before the trial judge that a juvenile court may deny a minor's petition for an abortion only if it finds that the minor is not mature and that an abortion would not be in her best interest. We advised the District Court that there was no opportunity for judicial authorization for an abortion to be withheld where a minor is found to be mature and competent to make the decision independently. (Pet. App. A. at A-16.)

The District Court rejected our interpretation of Section 188.028, and found the statute to be unconstitutional, solely for the reason that the judicial alternatives given to the juvenile court by the statute were connected by the disjunctive word "or." The trial court ruled that the statute allowed a juvenile court to choose the alternative of denying a minor's petition without requiring a prior finding that the minor was not sufficiently mature and competent to make an independent decision. (Pet. App. A at A-16.) In so interpreting the statute, the District Court found that Section 188.028 was contrary to the ruling in *Bellotti* v. *Baird*, 443 U.S. 622 (1979) (Bellotti II), thereby creating the absolute veto proscribed in *Planned Parenthood of Central Missouri* v. *Danforth*, 428 U.S. 52 (1976).

The defendants believe that the issue to be determined by this court is whether the decision of the Eighth Circuit substantially approving Missouri Revised Statute Section 188.028 comports with the most recent and complete statement by this Court concerning the manner in which minors can be required to obtain parental or judicial consent, as represented by *Bellotti II, supra.* To assist the Court in making its determination as to whether the decision of the Court of Appeals is in fact consistent with applicable Supreme Court precedent, there follows a complete outline of the holding of the Eighth Circuit respecting the constitutionality of Section 188.028.

The Eighth Circuit began its analysis of Section 188.028 by referring to the procedure outlined by Justices Powell, Burger, Rehnquist, and Stewart in *Bellotti* v. *Baird* (Bellotti II) which would satisfy constitutional requirements. *Id.* at 643-644. (Pet. App. B at A-65.) The lower court then compared the Missouri statutory
cedure, as stated in Section 188.028.2(4), with

cedure outlined by the four above-mentioned justices. The Missouri statutory procedure requires:

> "(4) In the decree, the court shall for good cause:
>
> (a) Grant the petition for majority rights for the purpose of consenting to the abortion; or
>
> (b) Find the abortion to be in the best interests of the minor and give judicial consent to the abortion, setting forth the grounds for so finding; or
>
> (c) Deny the petition, setting forth the grounds on which the petition is denied." (Pet. App. B. at A-66.)

The Eighth Circuit was cognizant of the fact that if the statute provides discretion to deny permission to a minor for *any* good cause, it would violate the principles set forth in *Danforth* and *Bellotti II.* However, the lower court reached the logical conclusion that:

> "[I]n the context of the statutory language, a denial of the petition would initially require the court to find that the minor was not emancipated and was not mature enough to make her own decision and that an abortion was not in her best interest. These findings and the ultimate denial of the petition must be supported by a showing of 'good cause.' When the statute is so interpreted and applied, it obviates Planned Parenthood's objections. Under these circumstances, we find the judicial consent provision of the Missouri statute constitutional." (Pet. App. B. at A-66.)

The lower court did not give the statutory section a completely clean slate, however. Section 188.028 also requires, on its face, the serving of notice to all parents of minors who petition for judicial consent to an abortion procedure. That parental notification provision of the Missouri statutory section was invalidated. (Pet. App. B. at A-68-69). The Eighth Circuit found that Missouri could not require parental notice in all cases in which judicial consent to an abortion of a minor was being sought because the parental notification provisions did not exclude mature or "best interest" minors from providing notice to their parents prior to a court hearing.

The Court of Appeals approved Section 188.028 as against the claim of plaintiffs that the use of the term "emancipated," as determinative of parental involvement in the abortion decision process, was overinclusive, underinclusive and vague. The Missouri statute exempts emancipated women under the age of 18 both from the requirement of parental consent and from the alternative requirement of a judicial proceeding. The lower court concluded that "emancipation" is a sufficiently accurate indicia of dependence on parental advice to serve as the basis for a legislative judgment by the Missouri legislature. (Pet. App. B. at A-69.)

Therefore, as modified by the action of the lower court in invalidating the requirement that parental notice be given with respect to all minors seeking judicial consent for an abortion, the Eighth Circuit upheld Section 188.028, rationally concluding that said statutory section is entirely consistent with the pronouncements of this Court in *Bellotti II*. It is with reference to those conclusions by the lower court, and in the context of those conclusions, that the question presented by Case No. 81-1255 must be resolved.

SUMMARY OF ARGUMENT

I. Except for that portion of the statute unvalidated for requiring notice to parents in all cases when the petition of a minor for an abortion is filed in juvenile court, the United States Court of Appeals for the Eighth Circuit upheld the constitutionality of Section 188.028, Revised Statutes of Missouri. The statute provides that, if a minor woman is emancipated, an abortion may be performed without parental consent or recourse to judicial proceedings. If she is unemancipated, an abortion may be performed upon the consent of one parent or guardian, or if the minor has been granted judicially the right to self-consent or if a court has found the abortion to be in her best interest.

The Court of Appeals painstakingly compared this Missouri statute with the procedure outlined by Justices Powell, Burger, Rehnquist and Stewart in *Bellotti* v. *Baird*, 443 U.S. 622, 643-644 (1979) *(Bellotti II)*. Except for the parental notification requirement which was stricken, the lower court found the statute consistent with the *Bellotti II* language. Plaintiff's arguments for reversing the Eighth Circuit, when separated from the accompanying rhetoric, amount to a challenge of the use of the disjunctive "or" in detailing the options available to a juvenile court upon a minor's abortion petition, and the alleged vagueness of the word "emancipated" in specifying minors for whom no consent, other than their own, is required.

II. The State of Missouri has a protectable interest in encouraging parental involvement in the abortion decision of their minor children, or, at the least, to require, as an alternative, a juvenile court, acting in *local parentis*, to determine if the minor is mature enough to make her own decision or if the abortion is in her best interest.

Prince v. *Commonwealth of Massachusetts,* 321 U.S. 158, 166 (1944); *Parham* v. *J.R.,* 442 U.S. 584, 602 (1979); *Bellotti* v. *Baird,* 443 U.S. 622, 639 (1979).

Section 188.028 directs a juvenile court, "for good cause", (a) to grant the petition for majority rights so the minor may consent, or (b) to find the abortion is in the best interest of the minor and give its consent, or (c) deny the petition setting forth the grounds for so doing. Before exercising any option, the court must receive evidence on "the emotional development, maturity, intellect and understanding of the minor . . . ." Rationally, the lower court found that a court could not deny a petition, "for good cause", unless it first found after having received the required evidence "that the minor was not emancipated and was not mature enough to make her own decision and that an abortion was not in her best interest." (Pet. App. B at A-66.) A juvenile court cannot deny a petition except for good cause, under Missouri law a cause or reason sufficient in law. Clearly, after *Bellotti II,* decided immediately before Section 188.028 was signed into law, there would be no legally sufficient reason to deny a petition if evidence demonstrated that a minor was sufficiently mature to make her own decision. The lower court correctly interpreted the statute and must be affirmed.

III. We find it difficult to believe that plaintiffs are seriously contending that the term "emancipated", as used to specify those minors for whom neither parental consent nor a judicial proceeding is required, is not sufficiently definite and commonly understood to provide appropriate notice. The Missouri legislature used a term of general usage to describe independence from parental influence, a term much fairer and more comprehensive than marriage.

Further, before a person may be successfully prosecuted for a violation of Section 188.028, it must be shown that he "knowingly" violated the section. Section 188.075, Revised Statutes of Missouri, 1981 Supplement. If the term is as confusing as plaintiffs claim, which is itself patently absurd, prosecution would depend on the element of scienter, i.e., the perpetrator must have known the minor was unemancipated.

Missouri has affirmatively exempted from the provisions of the statute minors who are emancipated, independent from the influence and control of their parents. The term is well defined by the Missouri common law, and is consistent with the interest of the state in maintaining the integrity of the family unit, when that unit is intact as to a pregnant minor. Under Missouri law, the emancipated child is one who is "physically and mentally able to take care of [herself] . . . , has voluntarily abandoned the parental roof and turned [her] . . . back to its protection and influence, and has gone out to fight the battle of life on [her] . . . own account. . . ." *Brosius* v. *Barker*, 136 S.W. 18, 19-20 (Mo. App 1911). Also, *Wurth* v. *Wurth*, 322 S.W.2d 745 (Mo. banc 1959).

ARGUMENT

The Court has granted its writ of certiorari upon the petition of the plaintiffs and the cross-petition of the defendants, and has consolidated the cases for purposes of briefing and oral argument. Taken together, the petition and cross-petition present for review five separate issues. The four issues presented in the cross-petition have been addressed in the defendant's initial brief on the merits, to which the plaintiffs are responding. This responsive brief is directed at the grant of certiorari and the initial brief of plaintiffs in Case No. 81-1255. Certiorari has been granted upon the petition of the plaintiffs to determine whether Section 188.028 of the Revised Statutes of Missouri is constitutionally valid in light of the previous pronouncements of this Court on the subject of parental and judicial consent for the performance of abortions on minors. The issue to be decided is whether the Appellate Court erred in upholding the constitutionality of Missouri Revised Statutes, Section 188.028.1 and Section 188.028.2 (1), (3), (4), (5), and (6), by construing the same to require a juvenile court, before it denied the petition of an unemancipated pregnant woman under 18 years of age seeking judicial consent to an abortion, to find that the minor was not emancipated and was not mature enough to make her own decision and that an abortion was not in her best interest.

The state statute at issue specifically outlines the procedure whereby an abortion may be performed upon a minor. If a pregnant woman under the age of 18 is emancipated, then an abortion may be performed upon her written consent alone without the approval of a parent or the consent of a court. If the minor is not emancipated, an abortion may be performed if the attending physician has secured the consent of one parent or guardian. However, the parents of an unemancipated minor are not granted an absolute veto over the abortion decision. An abortion may also be performed if the minor has been judicially granted the right to self-consent to the abortion or if a court has given its judicial consent to the abortion finding it to be in the best interest of the minor. The remainder of the statute specifies the procedure to be used if resort to a juvenile court is necessary.

In their initial brief, the plaintiffs have devoted sixteen pages of argument in support of their contention that Section 188.028 is constitutionally invalid. Reduced to the lowest common denominator, the plaintiffs' objections to the statute amount to an attack on the use of the disjunctive word "or" in describing the options available to the juvenile court in ruling upon a minor's petition for an abortion and the use of the term "emancipated" in specifying those minors for whom neither parental consent nor judicial proceedings are required. Therefore, the resolution of this case will require the highest judicial body in the United States to enter into a mundane exercise of statutory construction of the disjunctive and to decide whether the term "emancipated" is sufficient to put the prospective physicians of pregnant minor women under notice as to those who need not have parental consent nor apply to the court.

In Point I of this brief, we shall show that the United States Court of Appeals for the Eighth Circuit correctly concluded that Section 188.028, as modified by that court to exclude the requirement of parental notice when a petition is filed by a minor in juvenile court, is consistent with the procedure described by Justices Powell, Burger, Rehnquist and Stewart in *Bellotti* v. *Baird* (Bellotti II), 433 U.S. 622, 643-644 (1979). In Point II, the defendants submit that the term "emancipation" is a sufficiently accurate indicia of dependence on parental advice to serve as the basis for legislative judgment by the Missouri Legislature.

I.

The Missouri statutory requirement that, before an abortion may be performed on an unemancipated minor, one parent or guardian must consent or a court must grant the minor the right of self-consent or a court must grant its judicial consent on the grounds that the abortion is in the best interest of the minor, and the procedure outlined for judicial involvement in appropriate cases, is consistent with the guidelines established for statutes addressing this subject matter as pronounced by the court in Bellotti v. Baird (Bellotti II), 443 U.S. 622 (1979).

Addressing the constitutionality of Missouri statutory Section 188.028, the lower court did not completely absolve the statute from constitutional fault. To the contrary, the Eighth Circuit found unconstitutional the requirement embodied in Section 188.028.2(2) requiring parental notice in all cases where a petition for an abortion has been filed in the juvenile court. (Pet. App. B at A-69.) It is especially important to note that fact in order to refute the clearly erroneous assertion by the plaintiffs, at pages 14 and 15 of their brief, that the Missouri statute is invalid because it requires parental consultation or notification in every instance, citing specifically the subsection of the Missouri statute which had already been found unconstitutional by the Court of Appeals and which is not, therefore, before this Court for review. It is extremely misleading, even false, for the plaintiffs to claim that the Missouri statute, in its present form, includes the infirmity found to exist in the Massachusets statute at issue in *Bellotti* v. *Baird* (Bellotti II), 443 U.S. 622, 651

(1979). The Missouri statute does not require "parental consultation or notification in every instance without affording the pregnant minor an opportunity to receive an independent judicial determination that she is mature enough to consent or that an abortion would be in her best interest," as did the Massachusetts statute. *Id.* at 651.

We freely admit that Section 188.028 represents an effort by the Missouri Legislature to encourage parental involvement in the abortion decisions of minors, or, as an alternative, to involve the juvenile court, acting in *loco parentis,* to determine if the minor is mature enough to make her own decision or if the abortion is in her best interest. It is clear from Supreme Court precedent that the State of Missouri has a protectable interest in ensuring that unemancipated minors must secure either parental or judicial consent before they can obtain an abortion. As this Court stated in *Prince* v. *Commonwealth of Massachusetts,* 321 U.S. 158, 166 (1944), "It is cardinal . . . that the custody, care and nurture of the child reside first in the parents." Further, "[o]ur jurisprudence historically has reflected Western Civilization concepts of the family as a unit with broad parental authority over minor children. . . ." *Parham* v. *J. R.,* 442 U.S. 584, 602 (1979). Indeed, in *Meyer* v. *Nebraska,* 262 U.S. 390 (1923), and *Pierce* v. *Society of the Sisters of the Holy Names of Jesus and Mary,* 268 U.S. 510 (1925), the Court held that in some circumstances the Constitution compels a state to respect the traditional authority of a parent. As Mr. Justice Stephens stated in his opinion, concurring in part and dissenting in part, in *Planned Parenthood of Central Missouri* v. *Danforth,* 428 U.S. 52, 103-104:

> "It is unrealistic . . . to assume that every parent-child relationship is either (a) so perfect that communication and accord will take place routinely or (b) so im-

> perfect that the absence of communication reflects the child's correct prediction that the parent will [act] arbitrarily to further a selfish interest rather than the child's interest . . . . "

The Missouri statute under consideration provides no veto power to parents over a minor's abortion decision. In fact, the statute, as modified by the Eighth Circuit, even obviates the requirement of simple parental notice for mature minors or minors for whom abortion is in their best interest. Therefore, the Missouri statute differs fundamentally from the Missouri statute struck down in *Planned Parenthood of Central Missouri* v. *Danforth*, 428 U.S. at 90, which imposed "an absolute limitation on the minor's right to obtain an abortion."

Recognizing the important role of parents in the decisions of their children, the Court of Appeals in this case was required to, as in the case of the Massachusetts statute made the subject of *Bellotti II:*

> "[R]econcile the constitutional right of a woman, in consultation with her physician, to choose to terminate her pregnancy as established by *Roe* v. *Wade* [citation omitted] and *Doe* v. *Bolton* [citation omitted], with the special interest of the State in encouraging an unmarried pregnant minor to seek the advice of her parents in making the important decision whether or not to bear a child. . . ." *Bellotti* v. *Baird*, 443 U.S. at 639.

The *Bellotti II* Court went on to state concisely the question presented:

> [W]hether the Massachusetts [statute] provides for parental notice and consent in a manner that does not unduly burden the right to seek an abortion. *Id.*

Respondents respectfully submit that the Eighth Circuit properly reconciled the interests at stake, specifically applying the principles announced by this Court in *Bellotti II,* so that Section 188.028 should withstand judicial review. We ask that the Court recall its own caveat that there is "an important state interest in encouraging a family rather than a judicial resolution of a minor's abortion decision," and that a court considering a minor's request for judicial consent for abortion "may deny the abortion request of an immature minor in the absence of parental consultation if it concludes that her best interests would be served thereby or the court may in such case defer decision until there is parental consultation in which the court may participate." *Id.,* 443 U.S. at 648. This Court established the following guidelines in *Bellotti II:*

> [T]hat if the State decides to require a pregnant minor to obtain one or both parent's consent to an abortion, it also must provide an alternative procedure whereby authorization for the abortion can be obtained.
>
> A pregnant minor is entitled in such a proceeding to show either: (1) that she is mature enough and well enough informed to make her abortion decision, in consultation with her physician, independently of her parents' wishes; or (2) that even if she is not able to make this decision independently, the desired abortion would be in her best interests. The proceeding in which this showing is made must assure that a resolution of the issue, and any appeals that may follow, will be completed with anonymity and sufficient expedition to provide an effective opportunity for an abortion to be obtained. . . . *Id.,* 443 U.S. at 643-644.

The *Bellotti II* Court recognized also that, in a limited number of instances, it would not be advantageous to the minor to have to obtain parental consent prior to seeking an abortion or prior to seeking judicial consent to an abortion, and concluded:

> [T]hat under state regulation such as that undertaken by Massachusetts, every minor must have the opportunity—if she so desires—to go directly to a court without first consulting or notifying her parents. If she satisfies the court that she is mature and well enough informed to make intelligently the abortion decision on her own, the court must authorize her to act without parental consultation or consent. If she fails to satisfy the court that she is competent to make this decision independently, she must be permitted to show that an abortion nevertheless would be in her best interests. If the court is persuaded that it is, the court must authorize the abortion. If, however, the court is not persuaded by the minor that she is mature or that the abortion would be in her best interests, it may decline to sanction the operation. *Id.*, 443 U.S. at 647-648.

Against the foregoing analysis, the Eighth Circuit determined that it must approve the Missouri statutory section here involved. We submit that this Court should affirm, based upon similar analysis.

Section 188.028.1(1) requires that in all cases where an abortion is to be performed upon a woman under the age of eighteen years, the attending physician must secure the informed written consent of the minor and one parent, or guardian, *except* that under subsection (2) if the minor is emancipated, the abortion may be performed based solely on the informed written consent of the minor without any parental involvement or notification whatsoever. Further exceptions are embodied in subsection (3)(a) where, if the minor has been granted the right to self consent to the abortion by a juvenile court, no parental consent is required, and in subsection (4) where, if the juvenile court has given judicial consent to the abortion, no parental consent is required. At a juvenile court hearing, the court, pursuant to Section 188.028.2(3) must consider "the emotional development, maturity, intellect and understanding of the minor; the nature, possible consequences, and alternatives to the abortion; and any other evidence that the court may find useful in determining whether the minor should be granted majority rights for the purpose of consenting to the abortion or whether the abortion is in the best interests of the minor . . . ."

Under Section 188.028.2(4) the court may "(a) [g]rant the petition for majority rights for the purpose of consenting to the abortion . . . ." By this, if the court finds that the minor was sufficiently mature to give informed consent to the abortion herself, the court may grant her limited majority rights for that specific purpose. However, if the court finds that the minor is not sufficiently mature, he may nevertheless under subsection (b) "[f]ind the abortion to be in the best interests of the minor and give judicial consent to the abortion, setting forth the grounds for so finding . . . ." As a result, even an immature minor may be given judicial consent for an abortion, provided that the abortion is in her best interests, regardless of parental consent or the lack thereof.

The third alternative for the juvenile court is under subsection (c) for *"good cause"* to "[d]eny the petition, setting forth the grounds on which the petition is denied . . . ." In that case, there is provision for immediate appeal, and the statute provides further that "[b]ecause time may be of the essence regarding the performance of the abortion, the supreme court of this state shall, by court rule, provide for expedited appellate review of cases appealed under this section." Immediately after the effective date of this statutory enactment, the District Court enjoined enforcement. Therefore, as of this date, and because the petitioners have been granted a stay, Section 188.028 has not been enforced by the State of Missouri and there has been no need, to this point in time, for the state Supreme Court to promulgate rules concerning appellate review.

The defendants submit that the Missouri statute thereby cures both failings of the Massachusetts provision found unconstitutional in *Bellotti II*, because there is no requirement for parental consultation or notification prior to any judicial proceeding and because there is no opportunity for judicial authorization for an abortion to be withheld where a minor is found to be mature and competent to make the decision independently.

The Missouri statute also avoids the infirmities present in statutes invalidated in those lower court cases cited by the petitioners in their argument. An examination of the local statutes and ordinances involved in *Akron Center for Reproductive Health, Inc.*, v. *City of Akron*, 479 F.Supp. 1172 (N.D.Ohio 1979), and in *Scheinberg* v. *Smith*, 482 F.Supp. 529 (S.D.Fla. 1979) is illustrative. Not only does this statute comport with the guidelines announced in *Bellotti II*, but it is materially different from the ordinance stricken in *Akron Center for Reproductive Health, Inc.* v. *City of Akron, supra.* The Missouri statute exempts emancipated minors altogether, and provides that they may give consent to abortion. The Missouri statute further provides for self-consent for minors who demonstrate to the juvenile court that they are sufficiently mature to make an informed consent. Accordingly, the Missouri statute avoids the fatal flaw in the Akron city ordinance. In *Scheinberg* v. *Smith*, *supra*, the district court endorsed its order and opinion striking the Florida provision for abortion for unmarried minors as set forth in *Jones* v. *Smith*, 474 F.Supp. 1160 (S.D. Fla. 1979). The Florida statute required:

> "The court shall determine the best interest of the minor and enter its order in accordance with such determination." 474 F.Supp. at 1164.

The district court determined that:

> "The plain reading of the section indicates that the best interest standard overrides any basis for finding good cause under the criteria set forth in the preceding sentences if the judge determines that an abortion is not in the child's best interests. Therefore the statute unconstitutionally allows the judge to deny abortions to minors who are sufficiently mature to give informed consent." *Id*. at 1166.

The respondents respectfully submit that the Missouri statute does not provide the juvenile court with an opportunity to deny consent to abortion where the minor is sufficiently mature to give informed consent. As noted above, the Missouri statute exempts emancipated minors from these provisions altogether, and requires the juvenile court to grant majority rights for consent to abortion where the minor is mature and to give judicial consent to abortion where the abortion would be in the best interest of the petitioning minor. Only for good cause, a legally sufficient cause, may a juvenile court deny consent for abortion. The Missouri statute, therefore, meets the guidelines of *Bellotti II* while avoiding the problems noted in *Akron* and *Scheinberg* and should be sustained. Similarly, the Missouri statute, as analyzed by the Court of Appeals, avoids the infirmities present in other statutory provisions considered in the cases which have been cited by the petitioners.

The decision of the District Court invalidating Section 188.028, which was reversed by the Court of Appeals, was predicated entirely upon the fact that the options made available by statute to a juvenile court ruling upon a minor's petition for an abortion were connected with the disjunctive "or". (Pet. App. A at A-16.) The District Court concluded that the use of the disjunctive would allow the juvenile court to deny the petition without first finding that the minor was not sufficiently mature to make her own decision. This same theme is at the core of the interwoven arguments and complaints made by plaintiffs in their brief. The precise statutory language involved is as follows:

> "(4) In the decree, the court shall for *good cause;*
>
> (a) Grant the petition for majority rights for the purpose of consenting to the abortion; or
>
> (b) Find the abortion to be in the best interests of the minor and give judicial consent to the abortion, setting forth the grounds for so finding; or
>
> (c) Deny the petition, setting forth the grounds on which the petition is denied." (Emphasis added.) Section 188.028.2, RSMo Supp. 1981.

The Court of Appeals reversed the District Court. (Pet. App. B at A-66.) The appellate court found, in the context of the statutory language as a whole, that the petition of a pregnant minor could not be denied unless the juvenile court initially found that "the minor was not emancipated and was not mature enough to make her own decision and that an abortion was not in her best interest." We agree.

Each of the options made available to a juvenile court upon a petition of a pregnant minor for an abortion, set forth in Section 188.028.2(4), are preceded by the requirement that the court shall act "for good cause." The Missouri Supreme Court has defined "good cause" as "a cause or reason sufficient in law . . . ." *State* v. *Davis*, 469 S.W.2d 1, 5 (Mo. 1971). A cause or reason "sufficient in law", in light of the guidelines specifically provided by this Court in *Bellotti II*, would affirmatively require that before the petition of a minor is denied, the juvenile court must find that the minor is not sufficiently mature to make the abortion decision on her own. *Bellotti II* v. *Baird*, 443 U.S. at 651. Because of the language in *Bellotti II*, there cannot be good cause for denying a judicial petition for an abortion unless the court should first find that the petitioning minor is not herself mature and fully competent to make this decision independently.

Further, the simplistic approach by the District Court and by the plaintiffs ignores the language in the preceding subsection of the statute concerning the nature of the evidence which is to be heard during a hearing. Specifically, the Missouri legislature has required in such case that a juvenile court "shall hear evidence relating to the emotional development, maturity, intellect and understanding of the minor." Section 188.028.2(3). In denying a petition, a juvenile court may act "for good cause." That court may also "for good cause" grant the petition for majority rights or find the abortion to be in the best interests of the minor. The statute, having required certain specific types of evidence concerning maturity and intellect to be heard, mandates, in the first option provided to the juvenile court, that if there is "good cause" to believe that the minor is sufficiently mature to make her own decision that the petition for majority rights be granted. The statute requires that evidence concerning maturity be received. If the evidence is sufficient to establish that the minor is capable of making her own decision, then the "good cause" requirement would necessarily require that the petition be granted.

It is difficult to believe that the highest judicial tribunal in this nation is being called upon to rule a case revolving around the fact that the disjunctive word "or" appears between each of three judicial options provided for by state law. We believe that the Court of Appeals made the most reasonable interpretation of the statute. In addition, the requirement that a juvenile court act "for good cause", preceding each of the three options separated by the disjunctive, cures any defect which would otherwise exist. In the context of the statutory language, using the conjunctive would have made no sense whatsoever. A juvenile court could not exercise all three options. Where fairly possible, this Court should construe a statute so as to avoid a danger of unconstitutionality. *United States* v. *Harriss,* 347 U.S. 612, 618 (1954); *United States* v. *Delaware & Hudson Co.,* 213 U.S. 366 (1909); *United States* v. *Congress of Industrial Organization,* 335 U.S. 106, 120-121 (1948); and *United States* v. *Rumely,* 345 U.S. 41, 47 (1953).

Section 188.028 requires a juvenile court hearing the petition of a pregnant minor to receive evidence concerning her maturity. If the evidence is sufficient to establish that the minor is mature enough to make her own abortion decision, "good cause" does exist for the court to grant the petition for majority rights for the limited purpose of consenting to the abortion. In such case, "good cause" does not exist to deny the petition because evidence has established that the minor is mature enough to give her consent. That is the interpretation of the Court of Appeals. That interpretation should be affirmed and the statute should be upheld. We believe that the statute in question, reasonably interpreted as consistent with the clear legislative intent, does require, as the Court of Appeals found, that before the petition of a minor is denied, a juvenile court must find "that the minor was not emancipated and was not mature enough to make her own decision and that abortion was not in her best interest." (Pet. App. B. at A-66.)

At page 19 of their brief, the plaintiffs contend that Section 188.028 does not ensure a prompt judicial determination of a pregnant minor's petition. This allegation is conclusory without specifying alleged timeliness failures. In fact, the statute does clearly provide for an expedited proceeding. Section 188.028.2(3) requires that a hearing on a petition be held as soon as possible within five days of filing. If the minor is unable to afford counsel, the statute requires that the court appoint her counsel at least 24 hours before the hearing. Section 188.028.2(6) provides that if an appeal is taken from the action of the juvenile court, notice of appeal shall be given within 24 hours from the time the judicial order was issued. Further, the record on appeal shall be completed and the appeal shall be perfected within five days of the time the notice of appeal was filed. And, finally, "because time may be of the essence regarding the performance of the abortion," the statute requires the state Supreme Court to provide court rules for the expedited appellate review of cases under the statute. On the day after Section 188.028 was signed into law by the Governor of the State of Missouri, the District Court enjoined its enforcement. To date, no unemancipated pregnant minor has been required to comply with this statutory section before an abortion is performed. Therefore, there has been no need for the state Supreme Court to promulgate rules applying to appeals in this area. We believe that upon the affirmance by this Court of the Eighth Circuit's decision concerning the constitu-

tionality of this section, the Missouri Supreme Court shall proceed with all due diligence to enact relevant rules.

The defendants cannot allow to go unchallenged the language appearing at page 22 of the plaintiffs' brief, admonishing that this Court's appropriate recognition of the importance of parental imput into the decisions of minors and the importance of family unity, interests appropriately recognized by the statute at issue, must not be allowed to override the interests of the "family in formation." This admonition represents demagoguery at its most blatant. A pregnant minor seeking an abortion under the provisions of Section 188.028 is not a "family in formation." If she is married, the minor is emancipated and need not rely on this statute for the performance of an abortion. If she is not married, she need not gain consent of the prospective father and, if resorting to this statute, is attempting to avoid the imput of her parents. Finally, in seeking an abortion, that pregnant minor does not intend that she become a family or that a child be born.

Section 188.028 was enacted and signed into law at a time contemporaneous to this Court's deliberations and opinion in *Bellotti II*. Given the facts that the Missouri legislature did not have benefit of the opinion of the Court in that case, it is remarkable how closely the statute tracks the procedure recommended by Justices Powell, Burger, Rehnquist and Stewart. Although we assume that no abortion specific statute would be found acceptable by the abortion clinics and their employees who are plaintiffs in this case, or avoid nit-picking challenges by them, Section 188.028 clearly comports with the precedent of this Court precisely on point.

II.

By using the term "emancipation" to designate those pregnant women under the age of 18 who need neither

parental or judicial consent for an abortion, Section 188.028 has provided a sufficiently accurate indicia of dependence on parental advice to serve as a basis for legislative enactment.

In their brief, plaintiffs devote two pages to the proposition that "emancipated" is excessively vague and lacks specificity. Throughout this litigation, plaintiffs have demonstrated a fondness for characterizing certain state statutory provisions as overinclusive and underinclusive. There would be an overinclusive and underinclusive field day if the Missouri legislature had attempted to designate all possible factual situations which might indicate that a particular minor was sufficiently independent of a family unit so as to avoid the necessity of parental or judicial consent. The plaintiffs are tilting at windmills. Perhaps "emancipated" was chosen for attack because it is the only word of as many as five syllables in the entire statute.

The Court of Appeals rejected the objections of plaintiffs to the term "emancipated" in part because there is a scienter requirement necessarily prerequisite to a successful criminal prosecution for violation of Section 188.028. Criminal penalties for violation of Section 188.028 are provided by Section 188.075, RSMo Supp. 1981.

> "Any person who contrary to the provisions of sections 188.010 to 188.085 knowingly performs or aids in the performance of any abortion or knowingly fails to perform any actions required by sections 188.010 to 188.085 shall be guilty of a class A misdemeanor and, upon conviction, shall be punished as provided by law."

Therefore, if a physician performs an abortion upon a pregnant minor, having no notice of parental consent or of a judicial order granting the minor majority rights or finding the abortion in her best interests, he could not be successfully prosecuted unless it was shown that he knew his patient was not "emancipated". Section 188.075 requires a culpable mental state before a physician may be found guilty of a violation of Section 188.028.

The plaintiffs allege that the term "emancipated" is confusing and means different things to different people. We think they protest too much, especially in light of the fact that they seem to be able to formulate a definition of emancipation in arguing that the statute is underinclusive. (Pet. Br. at p. 16.) However, even if plaintiffs were correct in their contention that the term is vague, the alleged defect is cured by the culpability requirement above discussed. If a judge or jury did not believe that a particular physician defendant knew that a patient was not emancipated, that physician could not be successfully prosecuted.

The plaintiffs have evidenced much concern for the rights of pregnant minor women. That concern is laudable. Surely, it would be inconsistent with such concern for the state to have not excluded emancipated minors from the application of Section 188.028. By acting to exclude emancipated minors from the provisions of Section 188.028, the Missouri legislature has acted reasonably to protect the interests of minor women who are independent from the influence and control of their parents. Surely the plaintiffs do not suggest that emancipated minors should not be excluded from the provisions of the statute. Would the plaintiffs require a married minor living with her husband to secure parental or judicial consent before undergoing an abortion?

The plaintiffs have pointed out that the expert witness called to testify at trial did not provide uniform definition of the term "emancipation". That different individuals, when called upon to define emancipation, would refer to different factual situations or factors to be considered is to be expected because the indicia establishing emancipation in one case is not likely to be identical to the facts establishing emancipation in a different instance. Although there are general legal rules to interpret the existence of emancipation, and the term is one of general usage and understanding, nevertheless the question of emancipation must be determined upon the peculiar facts and circumstances of each individual case. Only general rules can be declared which will be applicable in all cases. *Brosius* v. *Barker*, 136 S.W. 18, 20 (Mo.App. 1911). Missouri law provides extensive guidance on the use of the term "emancipated". Although a state court of appeals case, *Brosius* v. *Parker, supra*, was accepted as expounding the most complete law on the subject until the Missouri Supreme Court handed down its decision in *Wurth* v. *Wurth*, 322 S.W.2d 745 (Mo. banc 1959), which was cited in a footnote to the opinion of the Court of Appeals. (Pet. App. B. at A-70.) We quote:

> "As to the quantum of proof necessary to establish voluntary emancipation, we note and quote excerpts from 67 C.J.S. Parent and Child § 88, pp. 812-814, as follows: 'The intention of the parent to emancipate the child may be expressed either in writing or orally, or it may be implied from his conduct or from other circumstances. * * * Emancipation may also be implied by the parent's acquiescence in his child's working for others, receiving its pay therefor, and spending the money as it pleases.' " *Wurth* v. *Wurth, id.* 322 S.W.2d at 746.

In *Brosius* v. *Barker, supra*, the following guidelines were established:

> "Complete emancipation is an entire surrender of all the rights to the care, custody and earnings of the child, as well as a renunciation of parental duties. [Citation omitted.] And the test to be applied is that of the preservation or destruction of the parental and filial relations. [Citation omitted.]
>
> "There are two types of emancipation, express and implied. Express emancipation takes places when the parent agrees with his child, who is old enough to take care of and provide for himself, that he may go away from home and earn his own living, and do as he pleases with the fruits of his labor. Implied emancipation is where the parent, without any express agreement by his acts or conduct, impliedly consents that his infant child may leave home and shift for himself. [Citations omitted.]
>
> * * * *
>
> "Without further declaring general rules, we hold that where the child, who is physically and mentally able to take care of himself, has voluntarily abandoned the parental roof and turned his back to its protection and influence, and has gone out to fight the battle of life on his own account, the parent is under no obligation to support him. [Citations omitted.]" *Brosius* v. *Barker, supra,* 136 S.W. at 19-20.

There is sufficient Missouri case law to provide ample notice as the meaning of the term "emancipated" as that term appears in Section 188.028. Further, the term has a common and generally accepted meaning. Specifying "emancipated" minors as those for whom no parental or judicial consent to an abortion was necessary, the Missouri legislature acted rationally and avoided the pitfall of limiting those minors excluded to married women. In

Wynn v. *Carey,* 582 F.2d 1375, 1387 (7th Cir. 1978), a state statute was invalidated partially because it excluded only married minors but included mature and emancipated minors. The Seventh Circuit used the specific term emancipated as explaining why the statute at issue in *Wynn* v. *Cary* was overinclusive. Section 188.028 avoids the problem of overinclusiveness and underinclusiveness by using the term "emancipated".

The purpose of the statute at issue is to encourage parental or judicial inolvement in the decisions of minors to abort. However, emancipated minors are excluded from the requirements of Section 188.028. The exclusion is consistent with the statute's purpose. The minor independent of the family unit, not dependent upon her parents for custody, care and nuture, should be allowed to make her own decisions with respect to the course of her pregnancy. Missouri does have a legitimate interest, however, in insuring that unemancipated minors either involve their parents in the abortion decision or petition a juvenile court so that an abortion may be performed. Emancipation is not a vague term. This Court should make that reasonable interpretation of a state statute which will avoid the danger of constitutional infirmatives. *United States* v. *Harriss,* 347 U.S. 612 (1954).

CONCLUSION

For the reasons herein submitted, the opinion of the United States Court of Appeals for the Eighth Circuit, insofar as it upheld the constitutional validity of Section 188.028 of the Revised Statutes of Missouri, should be affirmed.

Respectfully submitted,

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Petitioner's
Reply Brief

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No. 81-1255

IN THE

Supreme Court of the United States

OCTOBER TERM, 1981

PLANNED PARENTHOOD ASSOCIATION OF KANSAS CITY,
MISSOURI, INC., NAIM S. KASSAR, M.D.,
REPRODUCTIVE HEALTH SERVICES and ALLEN S. PALMER, D.O.,
Petitioners,

vs.

JOHN ASHCROFT, Attorney General of the State of Missouri,
and RALPH L. MARTIN, Prosecuting Attorney of Jackson
County, Missouri,
Respondents.

On A Writ Of Certiorari To The
United States Court of Appeals For The
Eighth Circuit

REPLY BRIEF OF PETITIONERS

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THE QUESTION PRESENTED FOR REVIEW

Whether the Appellate Court erred in upholding the constitutionality of Missouri Revised Statutes, §188.028.1 and §188.028.2(1), (3), (4), (5) and (6) by construing the same to require statutorily the approval of one parent or of the juvenile court for an unemancipated minor under eighteen years of age to terminate her pregnancy, even if she is found by the juvenile court to be mature enough to make her own personal decision; although such interpretation is contrary to the plain language of the challenged statute and is contrary to the interpretation placed thereon by the District Court?

THE CORRECTED QUESTION PRESENTED FOR REVIEW

Whether the Appellate Court erred in upholding the constitutionality of Missouri Revised Statutes, §188.028.1 and §188.028.2(1), (3), (4), (5) and (6) by construing the same to require statutorily the approval of one parent or of the juvenile court for an unemancipated minor under eighteen years of age to terminate her pregnancy, only if the juvenile court firstly determines that the granting to said minor her petition for majority rights for the purpose of consenting to the abortion is unjustified (§188.028.2[4][a]) and only if the juvenile court secondly determines that finding the abortion to be in the best interests of said minor and granting judicial consent to the abortion is unjustified (§188.028.2[4][b]); although such interpretation is contrary to the plain language of the challenged statute and is contrary to the interpretation placed thereon by the District Court?

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Respondents.

On A Writ Of Certiorari To The
United States Court of Appeals For The
Eighth Circuit

REPLY BRIEF OF PETITIONERS

CITATIONS TO OPINIONS AND JUDGMENTS DELIVERED IN THE COURTS BELOW

The initial opinion of the District Court on January 23, 1980 is reported at 483 F.Supp. 679 (W.D.Mo. 1980) and is reprinted in the Petition for Certiorari (No. 81-1255) at A-1 through A-51.

The order of the District Court on May 7, 1980 awarding fees and costs is reprinted in the Joint Appendix at 7-8.

The interlocutory opinion of the Court of Appeals on July 8, 1981 is reported at 655 F.2d 848 (8th Cir. 1981) and is reprinted in the Petition for Certiorari (No. 81-1255) at A-52 through A-108.

The "Opinion on Remand" of the District Court on October 2, 1981 is reprinted in the Joint Appendix at 9-23.

The supplemental and final opinion of the Court of Appeals on November 30, 1981 is reported at 664 F.2d 687 (8th Cir. 1981) and is reprinted in the Petition for Certiorari (No. 81-1255) at A-109 through A-117.

The order of the Court of Appeals on March 12, 1982 awarding fees and costs is reprinted in the Joint Appendix at 36-37.

STATEMENT OF JURISDICTIONAL GROUNDS

The judgment sought to be reviewed was issued and filed on November 30, 1981. The final judgment of November 30, 1981 incorporated the prior interlocutory judgment of July 8, 1981. Jurisdiction of this Honorable Court is predicated upon Title 28 United States Code, § 1254(1) and §2101(c). The Petition for Certiorari was filed on January 4, 1982 and granted on May 24, 1982. (50 U.S.L.W. 3934, May 24, 1982).

CONSTITUTIONAL AND STATUTORY PROVISIONS INVOLVED

The Fourteenth Amendment to the United States Constitution, in relevant part.

> Section 1. All persons born or naturalized in the United States, and subject to the jurisdiction thereof, are citizens of the United States and of the State wherein they reside. No State shall make or enforce any law which shall abridge the privileges or immunities of citizens of the United

States; nor shall any State deprive any person of life, liberty, or property, without due process of law; nor deny to any person within its jurisdiction the equal protection of the law.

Missouri Revised Statutes, §188.028

188.028. Minors, abortion requirements and procedure

1. No person shall knowingly perform an abortion upon a pregnant woman under the age of eighteen years unless:

(1) The attending physician has secured the informed written consent of the minor and one parent or guardian; or

(2) The minor is emancipated and the attending physician has received the informed written consent of the minor; or

(3) The minor has been granted the right to self-consent to the abortion by court order pursuant to subsection 2 of this section, and the attending physician has received the informed written consent of the minor; or

(4) The minor has been granted consent to the abortion by court order, and the court has given its informed written consent in accordance with subsection 2 of this section, and the minor is having the abortion willingly, in compliance with subsection 3 of this section.

2. The right of a minor to self-consent to an abortion under subdivision (3) of subsection 1 of this section or court consent under subdivision (4) of subsection 1 of this section may be granted by a court pursuant to the following procedures:

(1) The minor or next friend shall make an application to the juvenile court which shall assist the minor or next friend in preparing the petition and notices required pursuant to this section. The minor or the next friend of the minor shall therafter file a petition setting forth the initials of the minor; the age of the minor; the names and addresses of each parent, guardian, or, if the minor's parents are deceased and no guardian has been appointed, any other person standing in loco parentis of the minor; that the minor has been fully informed of the risks and consequences of the abortion; that the minor is of sound mind and has sufficient intellectual capacity to consent to the abortion; that, if the court does not grant the minor majority rights for the purpose of consent to the abortion, the court should find that the abortion is in the best interest of the minor and give judicial consent to the abortion; that the court should appoint a guardian ad litem of the child; and if the minor does not have private counsel, that the court should appoint counsel. The petition shall be signed by the minor or the next friend;

(2) Copies of the petition and a notice of the date, time, and place of the hearing shall be personally served upon each parent, guardian or, if the minor's parents are deceased and no guardian has been appointed, any other person standing in loco parentis of the minor listed in the petition by the sheriff or his deputy. If a parent or guardian or, if the minor's parents are deceased and no guardian has been appointed, any other person standing in loco parentis cannot be personally served within two days after reasonable effort, the sheriff or his deputy shall give constructive notice to them by certified mail to their last known address, and the hearing shall not be held for at least forty-eight hours from the time of the mailing. In any case where there exists the potential or appearance of conflict of in-

terests between the parents or guardian or next friend of the child and the child, the court shall appoint a guardian ad litem to defend the minor's interest. The court shall set forth, for the record, the grounds for such appointment;

(3) A hearing on the merits of the petition, to be held on the record, shall be held as soon as possible within five days of the filing of the petition. If any party is unable to afford counsel, the court shall apoint counsel at least twenty-four hours before the time of the hearing. At the hearing, the court shall hear evidence relating to the emotional development, maturity, intellect and understanding of the minor; the nature, possible consequences, and alternatives to the abortion; and any other evidence that the court may find useful in determining whether the minor should be granted majority rights for the purpose of consenting to the abortion or whether the abortion is in the best interests of the minor;

(4) In the decree, the court shall for good cause;

(a) Grant the petition for majority rights for the purpose of consenting to the abortion; or

(b) Find the abortion to be in the best interests of the minor and give judicial consent to the abortion, setting forth the grounds for so finding; or

(c) Deny the petition, setting forth the grounds on which the petition is denied;

(5) If the petition is allowed, the informed consent of the minor, pursuant to a court grant of majority rights, or the judicial consent, shall bar an action by the parents or guardian of the minor on the grounds of battery of the minor by those performing the abortion. The immunity granted shall only extend to the performance of the abortion in ac-

cordance herewith and any necessary accompanying services which are performed in a competent manner. The costs of the action shall be borne by the parties.

(6) An appeal from an order issued under the provisions of this section may be taken to the court of appeals of this state by the minor or by a parent or guardian of the minor. The notice of intent to appeal shall be given within twenty-four hours from the date of issuance of the order. The record on appeal shall be completed and the appeal shall be perfected within five days from the filing of notice to appeal. Because time may be of the essence regarding the performance of the abortion, the supreme court of this state shall, by court rule, provide for expedited appellate review of cases appealed under this section.

3. If a minor desires an abortion, then she shall be orally informed of and, if possible, sign the written consent required by section 188.039 in the same manner as an adult person. No abortion shall be performed on any minor against her will, except that an abortion may be performed against the will of a minor pursuant to a court order described in subdivision (4) of subsection 1 of this section that the abortion is necessary to perserve the life of the minor.

STATEMENT OF THE CASE

Missouri Revised Statutes, § 188.028 became law on June 29, 1979, as part of a comprehensive package of abortion regulation contained in Chapter 188. The challenged Section required the written consent of one parent or of the juvenile court to an abortion for an unemancipated minor under 18 years of age. A temporary restraining order was issued against enforcement of the challenged Section on June 30, 1979.

The District Court declared the challenged Section unconstitutional (483 F.Supp. 679, 687-690 [W.D. Mo. 1980]) (Pet. Cert. A12-A17) and the Appellate Court reversed, holding the Section constitutional (655 F.2d 848, 857-860 [8th Cir. 1981]) (Pet. Cert. A65-A70). (Incorporated into final order of November 30, 1981) (Pet. Cert. A117).

Both Petitioners' and Respondents' witnesses acknowledged that this challenged Section might well engender delays of 13 days or more, forcing many minors to pass into a later stage of pregnancy, thereby exposing them to substantially increased risks of morbidity and mortality. (J.A. 156).

Petitioners' experts were unanimous in their belief that mandating parental involvement in all instances was not in the best interests of the minor, abortion patient population. (J.A. 103, Palmer). "The younger the minor * * * the later she will be in her gestation when she seeks abortion services. The less available the abortion service, the longer she will wait. So it will tend to increase her risks rather than serve her health interest." (J.A. 123, Crist). Dr. Kretzschmar concurred that such a requirement is not "in the best interest of that patient population under the age of 18" (J.A. 127), as did Dr. Vera (J.A. 134).

Respondents' experts also agreed that this challenged Section would on occasion not be in the best interests of the minor. (J.A. 141, Ketterman). Respondents' expert Dr. Nathanson was also concerned with the health risks imposed by the delay he envisioned of "(s)omething on the order of two weeks" (J.A. 145), as was Respondent's expert Dr. Schmidt who acknowledged the possibility of danger in the Section's absolutism (J.A. 154). Respondents' expert Dr. Sym recognized that for a "significant percentage" of minors the delays imposed "would not be in their best health interests" (J.A. 156) and that the challenged Section imposes "a burden upon the delivery and availability of abortion services" (J.A. 156).

Petitioners' expert witnesses detailed the adverse compounding impact this challenged Section would have upon the availability and delivery of abortion services to minors. This would be so because minors delayed by the requirement of parental or judicial consent, also delay initially in seeking medical assistance for abortion by reason of psychological denial, and lack of sophistication and resources. Dr. Crist, drawing upon federal government statistics, testified that "50 per cent of the women age 12 and under who seek abortion services are pregnant by incest". (J.A. 122).

Petitioners' expert witnesses testified that the additional office visit required of minors under §188.028.2(1), prior to seeking court approval, would increase the total cost of the procedure by $10.00 to $25.00, by $35.00 (R. 219, Kassar), $15.00 to $50.00 (R. 350, Crist). They further testified that this challenged Section interferes with the traditional doctor-patient relationship (J.A. 103, Palmer; J.A. 127, Kretzschmar; R. 445, Vera) and seriously burdens the availability and delivery of abortion services (R. 135, Palmer; R. 324, Smith; R. 392, Kretzschmar; R. 446, Vera). Respondents' expert Dr. Ketterman stated in conclusion, "I am not in favor of this law exactly as it is written . . .," it "places a burden upon the delivery and availability of abortion services." (J.A. 141). Respondents' expert Dr. Nathanson also stated he would not support this challenged Section requiring parental involvement in all cases, thereby removing from the physician the ability to act in each case for the best interests of his or her patient. (J.A. 144-45).

It was Dr. Smith's considered opinion that "the minor herself is the best judge of whether her parents should be notified or not before she consents to abortions." (R. 313). Respondents' expert Dr. Sym approved of the Section in backhanded fashion, for he felt that a physician could fail to comply with it "if the doctor had a very good reason" and later "he would be able to defend himself against these charges successfully". (J.A. 156). He acknowledged that "many parents would fail to support a minor's decision to abort." (J.A. 156).

No two witnesses in the entire trial could agree on what the term "emancipated" in §188.028.1(2) means, and the same is not defined by the statute. Dr. Palmer had no idea of the criteria for emancipation (J.A. 103) and was aware of 14 year old women capable of giving an informed consent (J.A. 104). Dr. Kassar questioned "(i)f the person can calculate up to ten * * * * or tell me a good joke * * * * I don't understand it." (J.A. 110). "I wouldn't know how to determine that. * * * * It is confusing." (J.A. 118, Smith). "I wouldn't know how to use the emancipated portion of it." (J.A. 122, Crist). "It confuses me." (J.A. 133, Vera).

Respondents' experts were equally perplexed. "(A) young woman who is in any way still in need of guidance and advice and help from her parents * * * * is not truly an emancipated person * * * * (f)or the purposes of this section" (J.A. 138, Ketterman). As far as the definition of emancipated "I am really lost" (J.A. 140, Ketterman). "(E)ither marriage or prior birth is determinant" of emancipation (J.A. 145, Nathanson). "I can only guess," there would have to be "a prior legal proceeding in which the minor has been officially adjudicated to be emancipated." (J.A. 156, Sym).

The built-in delays of this challenged Section are enormous. A typical pattern of *prompt* compliance might well reflect the following: A minor, who previously having realized her pregnant state, having consulted her parents and having been refused consent, receiving the required information from the facility all on delayed day one. She must then file pleadings with the court on day two (§188.028.2[1]), allow for service on her parents on days three and four (§188.028.2[2]), allow for mailing or notice on days five and six (§188.028.2[2]), have a court hearing and decision on day seven (§188.028.2[3]-[4]), have an appeal filed on day eight (§188.208.2[6]), allow for perfection and decision on appeal on days nine through 14 (§188.028.2[6]) and then await an indeterminable period of time for an appellate decision and any subsequent appeal processes.

No other Missouri statute exists regulating any other medical or surgical procedure in this fashion; and this challenged Section applies to abortion at all stages of pregnancy. Dr. Kassar related the Missouri experience in 1974-1976 when parental involvement was mandated.

> First the patient went out of the state and * * * * we lost her. Second, the patient always comes late by the time they tell their parents. Third, some kids got kicked out of home, and, you know, some come with bruised eyes after they told their parents, and they come late. And some they never told their parents and they run away. (J.A. 109-10).

Dr. Smith related a case in which the parent refused consent to the minor because the parent wanted the child to raise and a three week delay ensued. (R. 296). Dr. Crist was also concerned that mandated "parental involvement would jeopardize * * * *" the minor patient's "well being." (J.A. 122). He felt that parental involvement in such cases "would increase her anxiety * * * *" and "the greater her anxiety and changes in body metabolism, her ability to cooperate with the medical setting, those contribute to an increased risk of complications and problems." (J.A. 123). As Respondents' expert Dr. Ketterman observed, "young women have gone into labor, a full-term pregnancy * * * * never having admitted to themselves or anyone else that they were pregnant." (J.A. 136).

The basis for federal court jurisdiction of this matter in the first instance was Title 28, United States Code, §1343(3) and Title 42, United States Code, §1983. (483 F.Supp. at 682, Pet. Cert. A1).

ARGUMENT

I. Policy Questions

To subject younger women to additional obstacles when electing abortion, will only adversely compound the medical realities that already disproportionately plague younger pregnant women. They have greater maternal mortality associated with live births. Cates, *et al., Standardized Mortality Rates Associated with Legal Abortion: United States, 1972-1975,* **Family Planning Perspectives**, Vol. 10, No. 2, p. 109 (March/April 1978). They have higher rates of divorce following birth of their first child. **Factbook on Teenage Pregnancy**, The Alan Guttmacher Institute (1981). They have greater infant mortality. *Shapiro, et al., Relevance of Correlates of Infant Deaths for Significant Morbidity at 1 Year of Age,* **American Journal of Obstetrics and Gynecology**, Vol. 136, No. 3, pp. 363, 366 (1980). In addition, the absence of any deleterious effects by abortion upon future childbearing has recently been judicially determined not to exceed a *de minimus* threshold. *Scheinberg* v. *Smith,* ____ F.Supp. ____ (S.D. Fla., No. 79-6403-Civ-SMA, Nov. 4, 1982).

It is also fallacious to assume that the mandating of parental involvement in a minor's abortion decision, results in the desired aim of parental consultation. In fact, the reverse appears to be true. In research supported by the Office of Family Planning, Bureau of Community Health, United States Department of Health and Human Services, it was found that:

> Mandatory notification procedures do not appear to promote parental involvement. On the other hand, policies which encourage rather than require teenagers to inform their parents of their participation in family planning programs are significantly related to higher levels of parental involvement.

Furstenberg, et al., Parental Involvement: Selling Family Planning Clinics Short, **Family Planning Perspectives,** Vol. 14, No. 3, pp. 140, 144 (May/June 1982).

II. The Question of Absention

The District Court interpreted §188.028.2(4) in a manner consistent with Petitioners' position.

> Defendants alternatively request that the Court abstain from ruling, citing *Bellotti I.* In that case the Supreme Court said that abstention is appropriate if an unconstrued state statute is susceptible to a construction which might avoid the need for federal constitutional adjudication,"[9] 428 U.S. at 146-47, 96 S.Ct. 2857, and found that particular statute susceptible to such a construction. It is clear to this Court that section 188.028 is not susceptible to a reasonable construction which would avoid the federal constitutional question controlling in *Bellotti II.* The statute permits the juvenile court to deny the minor's application but does not require that the court first find the minor not competent to make a decision independently. Accordingly, the Court declines to abstain.

(483 F.Supp. at 689-90, Pet. Cert. A-17).

The Circuit Court interpreted the same section in a manner consistent with Respondents' position.

> We would agree if the statute provides discretion to deny permission to a minor for *any* good cause it would violate the principles set forth in *Danforth* and *Bellotti II.* We believe, however, that in the context of the statutory language, a denial of the petition would initially require the court to find that the minor was not emancipated and was not mature enough to make her own decision and that

> an abortion was not in her best interests. These findings and the ultimate denial of the petition must be supported by a showing of "good cause". When the statute is so interpreted and applied it obviates Planned Parenthood's objections. Under these circumstances we find the judicial consent provision of the Missouri statute constitutional.

(655 F.2d at 858, Pet. Cert. A-68).

In light of the clear ambiguity of the section, as evidenced by the differing interpretations placed upon it by reasonable judicial minds; perhaps, the appropriate course of judicial restraint is abstention. As this Honorable Court has previously held under similar factual and legal circumstances:

> In deciding this case, we need go no further than the claim that the District Court should have abstained pending construction of the statute by the Massachusetts courts. As we have held on numerous occasions, abstention is appropriate where an unconstrued state statute is susceptible of a construction by the state judiciary "which might avoid in whole or in part the necessity for federal constitutional adjudication, or at least materially change the nature of the problem."

Bellotti v. *Baird,* 428 U.S. 132, 146-47 (1976). As noted just last year by this Honorable Court, "(w)e reaffirm that approach and find it controlling here insofar as appellant challenges a purported statutory exclusion of mature and emancipated minors". *H.L.* v. *Matheson,* 450 U.S. 398, 407 (1981).

Another important consideration involved in the doctrine of abstention enunciated by this Honorable Court is:

> Abstention is also appropriate where there have been presented difficult questions of state law bearing on policy problems of substantial public import whose importance transcends the result in the case then at bar.

Colorado River Water Conservation District v. *United States,* 424 U.S. 800, 814 (1976). This consideration is also present here.

CONCLUSION

The number of abortions performed for minors under 18 years of age has been decreasing in Missouri since 1979 and the ratio of pregnancies terminated, while increasing from 1975 to 1979, has remained static since 1979. *Trends in Missouri Abortions 1975-1980,* Missouri Center for Health Statistics Publication No. 4.25, June 1982. Table 11 at 30, 36, 42, 48, 54, 60 and supplemental unnumbered sheet for 1981.

The abortion experience in Missouri after 1974 has proven satisfactory to patients, their families and physician providers. To disrupt the *status quo* through the unwarranted interjection of the judicial process will cause undue hardship and turmoil upon all parties involved, including the courts.

Despite the best efforts of the Appellate Court to rewrite the challenged Section 188.028 under the pretense of statutory construction; its zealous intrusion into the legislative process can not be condoned. The Missouri General Assembly's ill-timed enactment, weeks before the enlightment offered by this Honorable Court in *Bellotti* v. *Baird,* 443 U.S. 622 (1979), can not be saved by a blurring of the lines delineating the separate branches of government.

The Missouri General Assembly is free to pass appropriate legislation governing minors and abortions, which comports with constitutional requirements. It has failed to do so in this instance and to date.

WHEREFORE, Petitioners pray that a Writ of Certiorari be issued to the Eighth Circuit Court of Appeals, reversing the judgment of that Appellate Court which sustained the constitutionality of Missouri Revised Statutes, §188.028.1 and §188.028.2(1), (3), (4), (5) and (6), or, in the alternative, reversing said appellate judgment and directing that the federal courts abstain, so as to allow a definitive interpretation of said Section by the Missouri courts, and for such further orders as this Honorable Court deems appropriate.

Respectfully submitted,

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MOTION FILED
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Nos. 81-185, 81-746 and 81-1172, 81-1255 and 81-1623

IN THE

Supreme Court of the United States

OCTOBER TERM, 1982

CHRIS SIMOPOULOS, M.D., FACOG,
Defendant-Appellant,
—v.—
COMMONWEALTH OF VIRGINIA,
State-Appellee.

CITY OF AKRON, et al.,
Defendants-Petitioners,
—v.—
AKRON CENTER FOR REPRODUCTIVE HEALTH, INC., et al.,
Plaintiffs-Respondents.

AKRON CENTER FOR REPRODUCTIVE HEALTH, INC., et al.,
Plaintiffs-Petitioners,
—v.—
CITY OF AKRON, et al.,
Defendants-Respondents.

(Caption continued on inside front cover)

ON APPEAL FROM THE SUPREME COURT OF VIRGINIA AND ON CERTIORARI
TO THE UNITED STATES COURT OF APPEALS FOR THE SIXTH CIRCUIT AND
THE UNITED STATES COURT OF APPEALS FOR THE EIGHTH CIRCUIT

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PLANNED PARENTHOOD ASSOCIATION OF KANSAS CITY,
MISSOURI, INC., et al.,
Plaintiffs-Petitioners,
—v.—
JOHN L. ASHCROFT, ATTORNEY GENERAL OF THE STATE
OF MISSOURI, et al.,
Defendants-Respondents.

JOHN L. ASHCROFT, ATTORNEY GENERAL OF THE STATE
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Nos. 81-185, 81-746 and 81-1172,
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In the
Supreme Court of the United States
October Term, 1982

Chris Simopoulos, M.D., FACOG,
Defendant-Appellant
v.
Commonwealth of Virginia,
State-Appellee

City of Akron, et al.,
Defendants-Petitioners,
v.
Akron Center for Reproductive Health,
Inc., et. al.,
Plaintiffs-Respondents

Akron Center for Reproductive Health,
Inc., et al.,
Plaintiffs-Petitioners
v.
City of Akron, et al.,
Defendants-Respondents

Planned Parenthood Association of
Kansas City, Missouri, Inc., et. al.,
Plaintiffs-Petitioners
v.
John L. Ashcroft, Attorney General
of the State of Missouri, et al.,
Defendants-Respondents

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v.
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Kansas City, Missouri, Inc., et al.,
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On Appeal from the Supreme Court of Virginia
and on Certiorari to the United States Court
of Appeals for the Sixth Circuit and the
United States Court of Appeals for the
Eighth Circuit

MOTION FOR LEAVE TO FILE BRIEF AMICI CURIAE OF CERTAIN LAW PROFESSORS

MOTION OF CERTAIN LAW PROFESSORS FOR LEAVE TO FILE BRIEF AMICI CURIAE

The above listed 85 law professors respectfully move the Court for leave to file the accompanying brief amici curiae, in support of defendant below in Simopoulos v. Virginia (No. 81-185); plaintiffs below on all issues in City of Akron v. Akron Center for Reproductive Health, Inc. (Nos. 81-746 & 81-1172); and plaintiffs below on all issues in Planned Parenthood of Kansas City, Missouri, Inc. v. Ashcroft (Nos. 81-1255 & 81-1623), with the exception of the question of statutory construction regarding minors' consent, on which we take no position.

Amici teach in American law schools. We submit this brief to share with the Court our support for the principles of constitutional law embodied in this Court's opinion in *Roe v. Wade*, 410 U.S. 113 (1973), and in the Court's subsequent applications of *Roe*. We believe that, as the ultimate guardian of the precious and delicate constitutional right of privacy as well as the final source of coherent constitutional doctrine, this Court must recognize the continuing validity of *Roe*. We, therefore, urge this Court to review with the strict judicial scrutiny used in *Roe* all enactments at bar regulating abortion procedures for adult women and to consider the regulations of abortions for minors against the special standard of review articulated by this Court in recognition of the unique status of children under the law.

We have sought the consent of the parties to file a brief amici curiae. Counsel for all parties in all three cases have consented, with the exception of counsel for the Commonwealth of Virginia in Simopoulos v. Virginia (No. 81-185).

Respectfully submitted,

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Nos. 81-185, 81-746 and 81-1172,
81-1255 and 81-1623

In the
Supreme Court of the United States
October Term, 1982

Chris Simopoulos, M.D., FACOG,
Defendant-Appellant
v.
Commonwealth of Virginia,
State-Appellee

City of Akron, et al.,
Defendants-Petitioners,
v.
Akron Center for Reproductive Health,
Inc., et. al.,
Plaintiffs-Respondents

Akron Center for Reproductive Health,
Inc., et al.,
Plaintiffs-Petitioners
v.
City of Akron, et al.,
Defendants-Respondents

Planned Parenthood Association of
Kansas City, Missouri, Inc., et. al.,
Plaintiffs-Petitioners
v.
John L. Ashcroft, Attorney General
of the State of Missouri, et al.,
Defendants-Respondents

John L. Ashcroft, Attorney General of
the State of Missouri, et al.,
Defendants-Petitioners
v.
Planned Parenthood Association of
Kansas City, Missouri, Inc., et al.,
Plaintiffs-Respondents

On Appeal from the Supreme Court of Virginia
and on Certiorari to the United States Court
of Appeals for the Sixth Circuit and the
United States Court of Appeals for the
Eighth Circuit

BRIEF *AMICI CURIAE* OF CERTAIN LAW PROFESSORS

This brief is submitted by the 85 listed individual amici curiae conditionally upon the granting of the attached motion for leave to file.

INTEREST OF THE AMICI

The interest of the amici is set forth in the attached motion for leave to file.

SUMMARY OF ARGUMENT

The constitutional right of privacy, a fundamental liberty shielded by the due process clause of the Fourteenth Amendment and so recognized by this Court in Roe v. Wade, 410 U.S. 113 (1973), presumptively relegates to the individual the intensely personal choice whether or not to terminate a pregnancy. This Court has explicitly determined on many occasions that this prima facie right encompasses freedom from direct governmental interference with the means to effectuate the abortion choice and that access to abortion is essential to the constitutionally protected right of decision.

When examining enactments regulating abortions sought by adult women, this Court has consistently used a two-step analysis: It has first decided whether the law directly interferes with or imposes any burden at all on the woman's freedom to choose abortion or to effectuate that choice. If the law does so, this Court has then applied strict judicial scrutiny, requiring the law to be not only justified by a compelling state interest but also narrowly tailored to further that goal. In the abortion context, this Court has identified just two state interests that will reach the "compelling point" -- preserving potential life after fetal viability and protecting maternal health after approximately the end of the first trimester.

This Court's precedents as well as the precious and delicate nature of the fundamental privacy right dictate that the enactments at bar regulating access to abortions for adult women be tested within the analytical framework described above. The balancing test or the sliding scale used as a standard of review by some lower courts would threaten all fundamental constitutional rights and would continually mire the courts in circular and standardless evaluations of the "burdensomeness" of every abortion regulation.

Because of the unique status of children under the law, this Court has required regulations of abortions sought by minors to be justified by significant state interests not present in the case of an adult, such as the interest in parental involvement. This Court's precedents have recognized, however, that to withstand constitutional attack these abortion regulations must allow mature minors to make their own decisions and must exempt from parental involvement minors whose best interests so require.

ARGUMENT

I.

The fundamental constitutional right of privacy, as elaborated by this Court in Roe v. Wade, protects a woman's abortion decision and her access to the means to effectuate that decision from the direct governmental interference imposed by the regulations now before this Court.

In Roe v. Wade, 410 U.S. 113 (1973), this Court held unconstitutional a Texas statute criminalizing all but life-saving abortions because the "right of privacy ... is broad enough to encompass a woman's decision whether or not to terminate her pregnancy." Id. at 153. In so holding, this Court did not decide that abortion is a desirable response to an unhealthful or unwanted pregnancy; instead, it recognized simply that the "Fourteenth Amendment's concept of personal liberty and restrictions upon state action" presumptively relegate such intensely personal and sensitive matters of conscience to individual choice, not government control. Id.; see Tribe, The Supreme Court, 1972 Term--Foreword: Toward a Model of Roles in the Due Process of Life and Law, 87 Harv. L. Rev. 1 (1973).

The prima facie constitutional right recognized in Roe belongs to the pregnant woman, Whalen v. Roe, 429 U.S. 589, 604 n.33 (1977), although this Court has made plain the indispensable role of her physician's best medical judgment in considering all factors relating to her pregnancy, in assisting her in the decisionmaking process, and in implementing her decision, should she choose abortion. See Roe, 410 U.S. at 153, 163; Doe v. Bolton, 410 U.S.

179, 192, 196-97 (1973); Connecticut v. Menillo, 423 U.S. 9 (1975); Colautti v. Franklin, 439 U.S. 379, 387 (1979). Abortion is, after all, a medical procedure, Roe, 410 U.S. at 166, and constraints on a physician's exercise of his best medical judgment necessarily interfere with "the woman's freedom to make a constitutionally protected decision," Whalen, 429 U.S. at 605 n.33.

The zone of privacy shielded by the Fourteenth Amendment, under Roe, encompasses not only "the interest in independence in making certain kinds of important decisions," Whalen, 429 U.S. at 599-600, but also the complementary and inseparable interest in being permitted to effectuate those decisions. See Paul v. Davis, 424 U.S.

693, 713 (1976) (emphasis added) ("limitations on States' power to substantively regulate *conduct*" in privacy matters). In other words, the interest that *Roe* found constitutionally secured is not just a theoretical interest in abstract decisionmaking on the subject of abortion; rather, this Fourteenth Amendment liberty necessarily includes protection from unjustified governmental interference with the means of effectuating a woman's abortion choice. Regarding the first trimester of pregnancy, for example, this Court held in *Roe* that "[i]f [the abortion] decision is reached, the judgment may be *effectuated* by an abortion free of interference by the State," 410 U.S. at 163 (emphasis added), and that "the abortion decision and its *effectuation* must be left to the medical judgment of the pregnant woman's attending physician," id. at 164 (emphasis added).

This principle was forcefully reaffirmed in Carey v. Population Services International, 431 U.S. 678 (1977), where this Court found its privacy precedents to "establish that the same test must be applied to state regulations that burden an individual's right to decide to prevent conception or terminate pregnancy by substantially limiting access to the means of effectuating that decision as is applied to state statutes that prohibit the decision entirely." Id. at 688. This Court reasoned that "access is essential to exercise of the constitutionally protected right of decision in matters of childbearing that is the underlying foundation of the [holding] in ... Roe v. Wade." Id. at 688-89. Thus, New York's restrictions on access to contraceptives, including a requirement that only licensed pharmacists distribute contraceptives, were invalid because they unjustifiably burdened the right of individuals to *use* such items. Id. at 686-90.

This Court's repeated reliance on the reasoning used in Roe to strike down restrictions falling far short of complete prohibitions of abortions clearly demonstrates the centrality of access to the means of effectuating the abortion decision. For example, Roe's reasoning was invoked in its companion case, Doe v. Bolton, to overturn the procedural provisions of Georgia's "modern" abortion legislation, including special hospitalization, accreditation, committee-approval, and two-doctor concurrence requirements. These requirements did not bar abortions altogether, and abortions remained available so long as physicians complied (under threat of criminal penalties) with these regulations. Nonetheless, this Court concluded that Georgia had, without sufficient justification, limited a physician's exercise of his best medical judgment--and thus derivatively his patient's right of privacy. 410 U.S. at 192-200. Three years later, Missouri's spousal consent requirement and its ban on saline amniocentesis (a then popular method of second-trimester abortion) fell when subjected to the analysis dictated by Roe and Doe. Planned Parenthood of Central Missouri v. Danforth, 428 U.S. 52 (1976).

Both requirements, provisions accompanied by criminal sanctions for noncompliance, blocked a woman's access without, however, completely prohibiting abortion.

The constitutional constraints that prevent government from interfering with the abortion choice and its effectuation do not require government actively to assist women to obtain abortions, even women unable to afford to pay for such treatment themselves. Harris v. McRae, 448 U.S. 297 (1980) (federal government); Williams v. Zbaraz, 448 U.S. 358 (1980) (states). Taking care to emphasize the continuing validity of the Roe doctrine, this Court has determined that government inaction--such as the failure to fund abortions for the indigent--simply does not impinge on the protected right to obtain an abortion, free from official interference. McRae, 448 U.S. at 314, 318.[1/]

The cases at bar raise a number of questions virtually identical to issues that this Court has resolved definitively in the past. The question of abortion access--or protection from direct interference with the means of effectuating the abortion decision--is squarely presented by the requirements that all abortions after the first trimester be performed in hospitals;[2/]

[1/] A well-defined line separates active or direct interference with the right recognized in Roe and governmental failure to provide abortions for all. See McRae; Maher v. Roe, 432 U.S. 464 (1977). See also Colautti v. Franklin, 439 U.S. 379, 386 n.7 (1979).

[2/] All three cases now before this Court present challenges to hos-

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that the attending physician personally inform the patient of facts relating to her pregnancy, the abortion procedure, fetal characteristics, agencies available to assist her, appropriate postoperative care, and the risks of the abortion technique to be used;[3] that the abortion patient wait

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pitalization requirements for all abortions performed after the first trimester.

[3] Plaintiffs below in Akron Center for Reproductive Health, Inc. v. City of Akron, 479 F.Supp. 1172 (N.D. Ohio 1979), aff'd in part, rev'd in part, 651 F.2d 1198 (6th Cir. 1981), cert. granted, 50 U.S.L.W. 3934 (U.S. May 25, 1982) (Nos. 81-746 & 81-1172), challenge provisions of an Akron, Ohio city ordinance containing the requirements described in text accompanying notes 3-4.

twenty-four hours between giving her informed consent and the performance of an abortion;[4/] that a second physician attend the abortion of a viable fetus;[5/] and that pathology reports by qualified pathologists be prepared following all abortions.[6/] Like the two-doctor concurrence and hospital-accreditation requirements invalidated

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[4/] *See* note 3 *supra*.

[5/] Plaintiffs below in *Planned Parenthood Ass'n. of Kansas City, Mo., Inc. v. Ashcroft*, 483 F.Supp. 679 (W.D. Mo. 1980), *aff'd in part, rev'd in part*, 655 F.2d 848 (8th Cir.), *on remand*, 664 F.2d 687 (8th Cir. 1981), *cert. granted*, 50 U.S.L.W. 3934 (U.S. May 25, 1982) (Nos. 81-1255 & 81-1623), challenge provisions of a Missouri statute containing the requirements described in text accompanying notes 5-6.

[6/] *See* note 5 *supra*.

in Doe and the spousal consent rule and saline amniocentesis ban overturned in Danforth, these restrictions do not entirely prohibit obtaining an abortion. Yet all of the limitations now before this Court, according to the records, make effectuating the abortion decision of adult women more onerous, more costly, more time-consuming, more difficult, and--sometimes--more hazardous.[7/]

7/ Courts have determined that mandatory waiting periods, like those imposed by the Akron ordinance, see note 4 and accompanying text supra, increase the health risks to the abortion patient by delaying the procedure as her pregnancy advances. See, e.g., Planned Parenthood Ass'n of Kansas City, Mo., Inc. v. Ashcroft, 655 F.2d 848, 866 (8th Cir. 1981) (48-hour waiting period), cert. granted, 50 U.S.L.W. 3934 (U.S. May 25, 1982) (Nos. 81-1255

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None of these enactments could even arguably be characterized as a mere failure to provide active governmental assistance, to be reviewed according to the analysis in the abortion-funding cases. See, e.g., Harris v. McRae, 448 U.S. 297 (1980). Instead, these enactments are state-created obstacles to abortion imposed through affirmative regulation of private conduct and policed with criminal

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& 81-1623); Planned Parenthood League v. Bellotti, 641 F.2d 1006, 1014 (1st Cir. 1981) (24-hour waiting period); Charles v. Carey, 627 F.2d 772, 785 (7th Cir. 1980) (24-hour waiting period). Hospitalization requirements, see note 2 supra, may also increase the health risks of abortion. See Ashcroft, 655 F.2d at 856-57.

penalties for noncompliance. They treat abortion differently from any other medical service, overriding standard medical practice and individual professional judgment. They interfere directly with the prima facie right of privacy of adult women elaborated in Roe, and they call for review against the standard used by this Court in Roe and in all subsequent abortion cases involving direct interference with the constitutional right of privacy of adult women: strict judicial scrutiny.[8/]

[8/] This Court's validation in Danforth of Missouri's written consent and recordkeeping requirements can easily be reconciled with the above con-

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clusions. The written consent requirement imposes no burden on the privacy right but simply verifies that the abortion decision is made by the individual to whom the protected privacy right belongs, the pregnant woman. The recordkeeping requirement, albeit for slightly different reasons, imposes "no legally significant impact or consequence on the abortion decision or on the physician-patient relationship." _Danforth_, 428 U.S. at 81. The Court's treatment of both these issues is elaborated further in part II B _infra_.

II.

This Court must scrutinize the abortion regulations now before it against the single standard, strict judicial scrutiny, consistently applied to all regulations directly imposing any burden on the adult woman's privacy right; a more relaxed test allowing ad hoc evaluations of the degree of the burden inflicted by abortion regulations would undermine a fundamental constitutional right, conflict with this Court's precedents, and create a judicially unmanageable standard for all fundamental-rights cases.

A.

Under Roe v. Wade, the abortion regulations now before this Court must be narrowly drawn to advance one of two possible compelling state interests: maternal health (compelling only after approximately the end of the first trimester) and potential life (compelling only after fetal viability).

This Court carefully explained that the liberty recognized in Roe v. Wade, although neither absolute nor unqualified, is a "fundamental right." 410 U.S. at 153-55. To withstand the strict judicial scrutiny evoked by such protected interests, any governmental restriction interfering with the right of an adult woman to terminate a pregnancy "may be justified only by a 'compelling state interest'" and "must be narrowly drawn to express only the legitimate state interests at stake." _Id_. at 155. _See_ _Carey v. Population Services International_, 431 U.S. 678, 686 (1977). The abortion regulations at bar must be tested against this standard.

In _Roe_ and its successors, this Court identified only two state interests that become sufficiently compelling at particular points in pregnancy to meet this test. First, a state's interest in protecting potential life becomes sufficiently compelling to justify abortion restrictions narrowly designed to further that goal only after viability, the point of fetal capacity for meaningful extrauterine survival. Roe, 410 U.S. at 163.[9/]

Second, the interest a state may assert in protecting maternal health matures to "the 'compelling' point" only at "approximately the end of the first trimester" of pregnancy, id. at 163, because until that time--according

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[9/] See also Planned Parenthood of Central Mo. v. Danforth, 428 U.S. 52, 63-65 (1976); Colautti v. Franklin, 439 U.S. 379 (1979).

to the medical literature available in 1973--"mortality in abortion may be less than mortality in normal childbirth," id; see id. at 149; Connecticut v. Menillo, 423 U.S. 9, 11 (1975). Restricting abortion during the first trimester because of the purported danger of the procedure would, therefore, only subject pregnant women to the greater health hazards posed by delivery, the inevitable end of an uninterrupted pregnancy. The logic of this conclusion necessarily transcends the particular timetable developed by this Court in 1973. Thus, as abortion techniques become more sophisticated, the comparative dangers of abortion at any point in pregnancy as opposed to childbirth will change. The post-first-trimester hospitalization requirements raised by all three cases now before this Court must be examined in this light.

After this "compelling point," the Constitution allows states to enact abortion regulations that "reasonably [relate] to the preservation and protection of maternal health." Roe, 410 U.S. at 163. The reference to "reasonableness" here not is a departure from application of the "compelling state interest" test, but instead reflects the analysis used by this Court to ascertain whether that test, with its requirement of narrowly tailored enactments, was satisfied: Abortion regulations that depart from established medical practices are insupportable on health grounds because they unnecessarily constrain the physician's exercise of his best medical judgment, recognized by this Court as the strongest safeguard of maternal health. See Doe v. Bolton, 410 U.S. 179, 192, 195, 197 (1973). They may therefore increase the risks of abortion without conferring any health benefits in return. They may also force women to undergo the often greater health risks of childbirth by limiting the availability of abortions. See Planned Parenthood of Central Missouri v. Danforth, 428 U.S. 52, 77-78 (1976). Such unnecessary abortion restrictions are, as a result, unreasonable on health grounds and thus are not narrowly drafted to advance a compelling state interest in protecting maternal health.

Because neither the interest in preserving potential life nor the interest in protecting maternal health is compelling during the first trimester of pregnancy, throughout that stage "the attending physician, in consultation with his patient, is free to determine, without regulation by the State, that, in his medical judgment, the patient's pregnancy should be terminated." Roe, 410 U.S. at 163. This Court has rejected the argument that a state has any sufficiently compelling interests to limit an adult woman's liberty to effectuate the abortion decision during the first trimester. *See* *id*. at 162-64.

B.

This Court's precedents dictate a two-step inquiry to ascertain whether the abortion regulations at bar are unconstitutional: do the regulations impose any burden at all on the abortion decision and its effectuation and, because these regulations directly impose such burdens, do they fail to satisfy the "compelling state interest" test?

In cases involving governmental interference with an adult woman's abortion decision or with her access to the means to effectuate that decision, this Court has never wavered from applying the "compelling state interest" test employed in *Roe*. *See* *Carey v. Population Services International*, 431 U.S. 678, 688 (1977) (same "compelling state interest" test must be applied to restrictions on abortion access as to complete prohibitions). For example, Georgia's special hospitalization and accreditation regulations, unable to withstand this Court's strict judicial scrutiny because they applied indiscriminately even to the first trimester, fell in Doe v. Bolton, 410 U.S. 179, 194-95 (1973). Similarly, a number of Missouri abortion restrictions, including a spousal consent requirement and a ban on saline amniocentesis, were declared unconstitutional because they failed to prove necessary to advance either of the two compelling state interests identified in Roe. Planned Parenthood of Central Missouri

v. Danforth, 428 U.S. 52, 69 (1976) (spousal consent law impermissibly covers even first trimester); id. at 79 (saline amniocentesis ban "fails as a reasonable regulation for the protection of maternal health").

This Court has applied a less stringent test to abortion laws only where the state has not acted affirmatively at all to impinge on a woman's right to obtain an abortion or where a regulation does not interfere--even to a minimal extent--with that right. Thus, for example, this Court has not applied the "compelling state interest" test to governmental failure to fund abortions for the indigent, inaction imposing "no restriction on access to abortions that was not already there." Maher v. Roe, 432 U.S. 464, 474 (1977); see Harris v. McRae, 448 U.S. 297 (1980). Similarly, simple written-consent and recordkeeping requirements have not evoked this Court's strictest scrutiny because these regulations in no way interfere with a woman's ability to decide to obtain an abortion and to effectuate that decision. A simple[10/] written-consent requirement merely assures that the abortion deci-

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[10/] The Court cautioned in Danforth that elaborate or detailed informed-consent requirements "might well confine the attending physician in an undesired and uncomfortable straitjacket in the practice of his profession," thus infringing the patient's right of privacy. 428 U.S. at 67 n.8.

sion has been made by the pregnant woman herself, the individual to whom the constitutional right of privacy belongs, see note 8 supra, while mandated recordkeeping of the sort considered in Danforth has "no legally significant impact or consequence on the abortion decision or on the physician-patient relationship," Danforth, 428 U.S. at 81 (emphasis added). See Whalen v. Roe, 429 U.S. 589, 607 (1977) (Brennan, J., concurring) (absent a deprivation of constitutionally protected liberty, state need not show law necessary to compelling state interest).

This Court's precedents thus unequivocally dictate a two-step inquiry for ascertaining the constitutionality of a challenged abortion regulation. First, a court must examine whether or not the regulation is state *action imposing any burden at all* on the right to obtain an abortion. The question here is not one of degree but simply whether the regulation affirmatively imposes any legally cognizable burden. If it does not, then the analytical framework developed in *Roe* does not govern. *See Danforth*; *Maher*; *McRae*. If, however, the regulation imposes any burden on the right recognized in *Roe*, then, as a second step, strict judicial scrutiny must be applied to determine whether that burden is undue--that is, whether it is properly justified by a compelling state interest and sufficiently narrowly tailored to further that goal. _See_ _McRae_, 448 U.S. at 314; _Maher_, 432 U.S. at 473-74.

Roe made plain the principles controlling during this second step of the inquiry: the lack of any compelling state interest during the first trimester of pregnancy, the compelling character of a state's interest in protecting maternal health only after the first trimester,[11/] and the compelling character of a state's interest in preserving potential life only after fetal viability. 410 U.S. at 163-64.

As noted earlier, all of the regu-

[11/] _But_ _see_ pages 23-24 _supra_.

lations now before this Court interfere directly with the right recognized in Roe; according to the records, they significantly burden the abortion decision and its effectuation by making termination of a pregnancy more onerous, more costly, more time-consuming, more difficult, and--sometimes-- more hazardous.[12/]

Under the strict judicial scrutiny that must therefore govern, all of the measures applicable to abortions sought by adult women during the first trimester must fall because neither state interest identified in Roe is sufficiently compelling during that stage

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[12/] See note 7 supra.

to support such restrictions. All of the first-trimester regulations challenged here are, consequently, "unduly burdensome." See McRae, 448 U.S. at 314, Maher, 432 U.S. at 473-74 (Roe doctrine "protects the woman from unduly burdensome interference with her freedom to decide whether to terminate her pregnancy"). These impermissible first-trimester regulations include the requirements that the attending physician personally inform the patient of facts relating to her pregnancy, the abortion procedure, fetal characteristics, agencies available to assist her, appropriate postoperative care, and the risks of the abortion technique to be used;[13] that the abortion patient wait twenty-four hours between the giving of her informed consent and the performance of an abortion;[14] and that pathology reports by qualified pathologists be prepared after all abortions.[15]

The measures before this Court regulating abortions after the first trimester must also be tested against the Roe standard. This Court must determine whether Missouri, Virginia and Akron, Ohio have established that their hospitalization requirements for all abortions performed after the first trimester are necessary to protect maternal health and that those requirements are drafted narrowly to achieve that legitimate goal.[16/] Current medical knowledge regarding the relative safety of various abortion techniques and the comparative risks of childbirth

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[13] See note 3 supra.

[14] See notes 3-4 supra.

[15] See notes 5-6 supra.

[16/] See note 2 supra. Because the constitutional right at stake is fundamental, the state (or city) bears the burden of satisfying the "compelling state interest" test. See, e.g., Roe, 410 U.S. at 155. See also Moore v. City of East Cleveland, 431 U.S. 494, 499 (1977) (plurality opinion). The court in Simopoulos v. Commonwealth, 277 S.E.2d 194, 204 (Va. 1981), probable jurisdiction noted, 50 U.S.L.W. 3934 (U.S. May 25, 1982) (No. 81-185), thus incorrectly presumed the constitutionality of Virginia's mandatory hospitalization law.

and abortion must figure in this analysis, as it has in this Court's precedents. See Roe, 410 U.S. at 163; Danforth, 428 U.S. at 76-79; part II A supra. For example, the finding by the district court in Ashcroft, affirmed by the court of appeals, regarding the comparable safety of D & E procedures inside and outside hospitals must be a determinative consideration. Planned Parenthood Association of Kansas City, Missouri, Inc. v. Ashcroft, 664 F.2d 687, 690 (8th Cir. 1981), cert. granted, 50 U.S.L.W. 3934 (U.S. May 25, 1982) (Nos. 81-1255 & 81-1623).

Similarly, Missouri's law mandating the attendance of a second physician at the abortion of a viable fetus[17/] will survive the required strict scrutiny only if determined to be narrowly tailored to advance the state's interest in preserving potential life after the relevant "compelling point," fetal viability. See Colautti v. Franklin, 439 U.S. 379 (1979). The district court, affirmed by the court of appeals, found this law unconstitutionally overbroad because it covered even those abortions which maternal health considerations required to be performed by means incompatible with

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17/ See note 5 supra.

fetal survival.[18/] Planned Parenthood Association of Kansas City, Missouri, Inc. v. Ashcroft, 655 F.2d 848, 865-66 (8th Cir. 1981), cert. granted, 50 U.S.L.W. 3934 (U.S. May 25, 1982) (Nos. 81-1255 & 81-1623).

In sum, Roe and its successors dictate the controlling standard of review, strict scrutiny, that must apply to the regulations challenged here as well as the identity and scope of the two state interests that may be sufficiently compelling to support narrowly drawn abortion limitations.

[18/] Under Roe, even though a state may generally go so far as to proscribe post-viability abortions, it cannot do so in cases where maternal life or health would be jeopardized. 410 U.S. at 164, 165.

C.

Only the "compelling state interest" test--applied here and in all fundamental-rights cases--promises adequate protection of fundamental constitutional rights, consistency with this Court's precedents, and elimination of the uncertainty that a variable standard of review resting on ad hoc assessment of burdens generates.

The reasons are plain why this Court will continue to adhere to the two-step inquiry dictated by its precedents, instead of resorting to a balancing test[19/] or sliding

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[19/] Akron Center for Reproductive Health, Inc. v. City of Akron, 479 F. Supp. 1172, 1200 (N.D. Ohio 1979) (defining balancing test). See id. at 1207 (applying balancing test).

The district court in the Akron case (Nos. 81-746 & 81-1172) used a balancing test on the theory that only

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scale[20/] based upon ad hoc evaluations

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an absolute prohibition or veto of the abortion decision must be justified by a compelling state interest and narrowly drawn to further that goal. "Lesser" invasions of the privacy right require a court simply to weigh the "degree" of interference against "any valid state interest furthered by such" regulation. *Id.* at 1200.

The district court's erroneous conclusion about the appropriate standard of review stems from its effort to read this Court's treatment of direct interference with an adult woman's right of privacy together with the opinions in two very different areas: cases concerning the privacy rights of minors, where this Court has applied a distinct standard of review, *see* part III *infra*, and the abortion-funding cases, where the lack of any active governmental interference with the abortion decision eliminates the need for strict scrutiny, *see*, *e.g.*, *Harris v. McRae*, 448 U.S. 297 (1980).

[20/] Judge Kennedy, concurring in part and dissenting in part in the *Akron*

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of the degree of the burden arguably imposed by each and every abortion regulation.

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case (Nos. 81-746 & 81-1172), fashioned a sliding scale under which the intensity of the judicial scrutiny is determined by the degree of the burden an abortion regulation imposes. Unlike the district court, see note 19 supra, Judge Kennedy would not confine strict scrutiny to absolute prohibitions and vetoes of the abortion decision. Akron Center for Reproductive Health, Inc. v. City of Akron, 651 F.2d 1198, 1215 (6th Cir. 1981) (Kennedy, J., concurring and dissenting). Unlike the majority of the court of appeals, however, Judge Kennedy would eschew the two-step inquiry and would decline to apply strict scrutiny to all restrictions imposing any burden on the abortion decision. Id. n.5.

The basic flaw in Judge Kennedy's analysis is the same as that in the district court opinion: an attempt to unify several clearly and explicitly distinguished lines of cases. See note 19 supra.

First, as this Court emphasized decades ago, "it is the character of the right, not of the limitation, which determines what [constitutional] standard governs the [legislative] choice." Thomas v. Collins, 323 U.S. 516, 530 (1945). That principle remains sound law today. See Schad v. Borough of Mount Ephraim, 452 U.S. 61, 68 (1981). Constitutional rights properly deemed fundamental, such as the right to decide to terminate a pregnancy and the right to effectuate that decision, require the vigorous protection from governmental intrusions that only strict judicial scrutiny, applied to every direct interference or burden, affords.

The right of privacy, in particular, which limits the government's power to intervene in intensely personal decisions and their effectuation, demands the most stringent standard of judicial review. A matter as sensitive as whether or not to terminate a pregnancy--fraught as it is with intractable questions about the beginning of human life--simply cannot be left to majoritarian resolution, under which any number of impediments to abortion might be reasonable if predicated upon one of several competing and ultimately unverifiable theories of human existence. This Court has thus recognized that the Fourteenth Amendment's due process clause prima facie guarantees to the individual the power to resolve such questions. Roe v. Wade, 410 U.S. at 162 (Texas may not override the rights of the pregnant woman by adopting one theory of life); Bellotti v. Baird, 443 U.S. 622, 655 (1979) (Stevens, J., concurring) ("It is inherent in the right to make the abortion decision that the right may be exercised without public scrutiny and in defiance of the contrary opinion of the sovereign...."); Tribe, The Supreme Court, 1972 Term--Foreword: Toward a Model of Roles in the Due Process of Life and Law, 87 Harv. L. Rev. 1 (1973).

This Court has carefully crafted the "compelling state interest" test so that truly overriding governmental concerns, if advanced by narrowly drafted laws, can impinge on fundamental liberties, including the right of privacy. Under such circumstances, a deprivation of liberty is constitutionally justified, and the ultimate judgment will be that that deprivation is not "unduly burdensome." _See generally_ Note, _Of Interests, Fundamental and Compelling: The Emerging Constitutional Balance_, 57 B.U.L. Rev. 462 (1977). To suggest, as some lower courts have, that strict scrutiny controls only when the burden on the privacy right is thought, in the first instance, to be "undue"[21/] is to turn this Court's preservation of individual constitutional rights on its head. Lowering the standard of review for

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[21/] See, e.g., Leigh v. Olsen, 497 F.Supp. 1340, 1343, 1346 (D.N.D. 1980) (regulations not unduly burdening abortion decision need be only rational; statute requiring patient to be informed of alternatives to abortion bears reasonable relation to informed consent and state's preference for childbirth). But see Charles v. Carey, 627 F.2d 772, 777 (7th Cir. 1980): "[T]he term 'undue burden' defines the ultimate constitutional issue, not merely the threshold requirement for strict scrutiny." Other courts have adopted this well-reasoned statement of the law. E.g., Planned Parenthood Ass'n of Kansas City, Inc. v. Ashcroft, 655 F.2d 848, 855 (8th Cir. 1981), cert. granted, 50 U.S.L.W. 3934 (U.S. May 25, 1982) (Nos. 81-1255 & 81-1623); Akron Center for Reproductive Health, Inc. v. City of Akron, 651 F.2d 1198, 1204 (6th Cir. 1981), cert. granted, 50 U.S.L.W. 3934 (U.S. May 25, 1982) (Nos. 81-746 & 81-1172).

arguably "lesser" infringements would eviscerate the protection of fundamental rights by sustaining such infringements even if overbroad or unrelated to a compelling interest.[22]

Moreover, because the operative element in such analysis would be the perceived degree of the burden imposed, no unique feature of abortion litigation would confine this variable standard of review to those cases alone; all fundamental rights would be equally susceptible of such diluted protection. _See_ Appleton, _Beyond the Limits of Reproductive Choice: The Contributions of the Abortion-Funding Cases to Fundamental-Rights Analysis and to the Welfare-Rights Thesis_, 81 Colum. L. Rev. 721, 752-53 (1981).

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[22] For example, the district court in the _Akron_ case sustained several first-trimester abortion regulations (including a detailed "informed-consent" requirement and a mandatory twenty-four-hour waiting period) because they furthered "valid state interests in maternal health and welfare" without cumulatively making abortion "so much more expensive" as to effect a veto of a woman's decision. _Akron Center for Reproductive Health, Inc. v. City of Akron_, 479 F. Supp. 1172, 1207 (N.D. Ohio 1979), _aff'd in part, rev 'd in part_, 651 F.2d 1198 (6th Cir. 1981), _cert. granted_, 50 U.S.L.W. 3934 (U.S. May 25, 1982) (Nos. 81-746 & 81-1172).

Apart from the precious and delicate nature of the privacy right and the resulting need for heightened judicial protection, the analytical framework that this Court has consistently followed since _Roe_ must be retained because it is the only one capable of coherent judicial administration. Use of a balancing test[23/] or a sliding scale[24/] in order to set a standard of review is entirely unworkable for two reasons.

First, it is circular. It purports to prescribe a standard of review that will guide the consideration of various factors but in truth it brings all those factors into play in _setting_ the standard.[25/] Such circularity is obviously untenable and could only raise questions about the foundation and consistency of the decisions rest-

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[23/] _See_ note 19 _supra_.

[24/] _See_ note 20 _supra_.

[25/] _See_ note 21 _supra_.

ing on such reasoning. In contrast, the Roe analysis is entirely straightforward. And whatever may be said about the outcome-determinative quality of strict judicial scrutiny in other contexts,[26] this Court's identification in Roe of two state interests that eventually do become compelling demonstrates that strict scrutiny in abortion cases does not "merely [announce] an inevitable result"[27]--unconstitutionality--but instead signals an adjustment between protected rights and truly overriding governmental concerns.

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[26] See Gunther, The Supreme Court, 1971 Term--Foreword: In Search of Evolving Doctrine on a Changing Court: A Model for Newer Equal Protection, 86 Harv. L. Rev. 1, 8 (1972).

[27] Widmar v. Vincent, 102 S.Ct. 269, 279 n.3 (1981) (Stevens, J., concurring); Illinois State Bd. of Elections v. Socialist Workers Party, 440 U.S. 173, 188-89 (1979) (Blackmun, J., concurring).

Beyond its circularity, a balancing test or sliding scale is ultimately standardless. How are the degrees of interference or burden to be determined? Under a balancing test, how much additional cost[28/] must be imposed or how great must be the additional health risks before the burden of an abortion regulation outweighs, for example, a pre-viability state interest in protecting potential life? Or is "burdensomeness" measured by the number of abortions the regulation actually curtails? Under the sliding scale, how much additional cost, how great the

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[28/] *See* note 22 *supra*.

health risks, or how many foregone abortions would be necessary before strict scrutiny would govern?

Instead of according more deference to state and local governments, such weaker standards of review--with their intrinsic indeterminacies--would only multiply the number of federal-state clashes, as federal courts at all levels struggled to implement that regime. The various lower courts would undoubtedly reach conflicting conclusions about the "burdensomeness" of all manner of regulations, thereby increasing the uncertainty in fundamental-rights cases generally and, in particular, compelling this Court's continuing role as the arbiter of the permissibility of every state's and every city's abortion laws.

III.

Because of the unique status of children under the law, this Court has used a special standard of review for regulations of abortions for minors, requiring states to allow mature minors to make their own abortion decisions and to free from parental involvement all those minors whose best interests so demand.

Children have occupied a unique status throughout this Court's constitutional adjudication. As a plurality of this Court observed in Bellotti v. Baird, 443 U.S. 622 (1979): "Children have a very special place in life which law should reflect. Legal theories and their phrasing in other cases readily lead to fallacious reasoning if uncritically transferred to determination of a State's duty towards children." Id. at 633-34 (plurality opinion) (quoting May v. Anderson, 345 U.S. 528, 536 (1953) (Frankfurter, J., concurring)). Hence, "constitutional principles [must] be applied with sensitivity and flexibility to the special needs of parents and children." Bellotti, 443 U.S. at 634 (plurality opinion).

Certainly, the Constitution protects minors as well as adults. See, e.g., In re Gault, 387 U.S. 1, 13 (1967). Moreover, as this Court has recognized, adolescent pregnancy is a widespread and personally devastating occurrence.[29] Yet because of the

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[29] See Michael M. v. Superior Court, 450 U.S. 464, 470-71 (1981) (plurality opinion); id. at 479

(Footnote continued on following page)

unique status of children under the law, this Court has applied a special standard of review in cases examining the privacy rights of minors: "whether there is any significant state interest [supporting the regulation] that is not present in the case of an adult." Planned Parenthood of Central Missouri v. Danforth, 428 U.S. 52, 75 (1976); Carey v. Population Services International, 431 U.S. 678, 693 (1977) (plurality opinion). As a plurality of this Court explained in Carey, 431 U.S. at 693 n.15:

Footnote continued

(Stewart, J., concurring); id. at 481-82 (Blackmun, J., concurring); Carey v. Population Servs. Internat'l, 431 U.S. 678, 696 & n.21 (1977) (plurality opinion).

> This test is apparently less rigorous than the "compelling state interest" test applied to restrictions on the privacy rights of adults. Such lesser scrutiny is appropriate both because of the States' greater latitude to regulate the conduct of children, Prince v. Massachusetts, 321 U.S. 158 (1944); Ginsberg v. New York, 390 U.S. 629 (1968), and because the right of privacy implicated here is "the interest in independence in making certain kinds of important decisions," Whalen v. Roe, 429 U.S. 589, 599-600 (1977), and the law has generally regarded minors as having a lesser capability for making important decisions. See, e.g., Planned Parenthood, 428 U.S., at 102 (Stevens, J., concurring in part and dissenting in part).

This Court's repeated emphasis of the long held and deeply rooted doctrine according minors a unique status under the law, see Bellotti; Danforth, 428 U.S. at 74-75; Ginsberg v. New York, 390 U.S. 629, 638-41 (1968); Prince v. Massachusetts, 321 U.S. 158, 170 (1944), explicitly refutes any theory, such as that embraced by Judge Kennedy, writing separately in the Akron case, that all of this Court's privacy precedents -- those concerning minors as well as adults -- should be read together as the source of a universal, sliding-scale standard of review for abortion regulations, whether applicable to minors or adults. See Akron Center for Reproductive Health, Inc. v. City of Akron, 651 F.2d 1198, 1211-15 (6th Cir. 1981) (Kennedy, J., concurring and dissenting), cert. granted, 50 U.S.L.W. 3934 (U.S. May 25, 1982) (Nos. 81-746 & 81-1172). See also Akron Center for Reproductive Health v. City of Akron, 479 F. Supp. 1172, 1198-1200 (N.D. Ohio 1979). This

Court's precedents plainly recognize that minors' abortion rights pose problems distinct from those affecting adults and demand a distinct standard of review.

This Court has identified three concerns uniquely relevant to minors: "the peculiar vulnerability of children; their inability to make critical decisions in an informed, mature manner; and the importance of the parental role in child rearing." Bellotti, 443 U.S. at 634 (plurality opinion). Although these special concerns will not support a state-granted parental veto over a minor's abortion decision, Danforth, 428 U.S. at 74-75, a majority of the Justices of this Court would approve a more narrowly drafted statute allowing minors judicially determined to be mature to make their own abortion decisions while requiring immature minors to obtain a consent-substitute, parental permission or judicial authorization predicated upon a determination of the minor's best interests. See Bellotti, 443 U.S. at 643-44 (plurality opinion for four Justices); id. at 656-57 (White, J., dissenting) (expressing approval of even absolute parental consent requirement).

Similarly, this Court has validated a parental notification requirement because it served not only "the important considerations of family integrity and protecting adolescents" but also "a significant state interest by providing an opportunity for parents to supply essential medical and other information to a physician." H.L. v. Matheson, 450 U.S. 398, 411 (1981). This Court did not, however, extend that holding to mature or emancipated minors or to immature minors showing such notification detrimental to their best interests. 450 U.S. at 407 & n.14.

The abortion regulations at bar pertinent to minors must be tested against the special standard of review and in light of the special concerns for minors and their parents articulated by this Court in the past. Under these guidelines, the district court and the court of appeals correctly held unconstitutional Akron's requirement of parental or judicial consent for abortions for all minors under the age of fifteen. Akron Center for Reproductive Health, Inc. v. City of Akron, 479 F. Supp. 1172, 1201 (N.D. Ohio 1979), aff'd in part, rev'd in part, 651 F.2d 1198, 1205 (6th Cir. 1981), *cert. granted*, 50 U.S.L.W. 3934 (U.S. May 25, 1982) (Nos. 81-746 & 81-1172). This provision--enacted before this Court's decision in *Bellotti*--impermissibly allows parents or, alternatively, a court to veto the abortion choice of even a minor under the age of fifteen years who is sufficiently mature to reach that decision herself. *See Bellotti*, 443 U.S. at 643-44 (plurality opinion). Moreover, it contains no procedural safeguards that ensure an abortion for an immature minor under the age of fifteen years whose best interests require termination of her pregnancy without any parental involvement.[30] *See id.* at 651. *See also*

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[30] Where, as here, the class addressed consists of pregnant minors below the age of fifteen, the procedures

(Footnote continued on following page)

H.L., 450 U.S. at 413-20 (Powell, J., concurring, joined by Stewart, J.) (some minors' best interests require exemption from parental notification); id. at 446, 452-53 (Marshall, J., dissenting, joined by Brennan and Blackmun, JJ.) (same).

Without such exceptions and safeguards, this provision of the Akron ordinance fails as unconstitutionally overbroad.

CONCLUSION

For all of the reasons stated, the 85 amici respectfully submit that the prima facie privacy right recognized

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Footnote continued

purportedly offering a meaningful alternative to parental involvement must be clearly described and easily understood. This provision of the Akron ordinance, referring only to "a court having jurisdiction," fails this test. See 479 F. Supp. at 1201.

in Roe v. Wade includes freedom to effectuate the abortion choice without government interference; that the strict judicial scrutiny used in Roe and its progeny must apply to all enactments at bar regulating abortion procedures for adult women; and that the special standard of review articulated by this Court in recognition of the unique status of children under the law must apply to the enactments at bar regulating abortion procedures for minors.

Respectfully submitted,

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Amicus Brief

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Nos. 81-185, 81-746 and 81-1172, 81-1255 and 81-1623

IN THE

Supreme Court of the United States

OCTOBER TERM, 1982

CHRIS SIMOPOULOS, M.D., FACOG,
Defendant-Appellant,
—v.—
COMMONWEALTH OF VIRGINIA,
State-Appellee.

CITY OF AKRON, et al.,
Defendants-Petitioners,
—v.—
AKRON CENTER FOR REPRODUCTIVE HEALTH, INC., et al.,
Plaintiffs-Respondents.

(Caption continued on inside front cover)

ON APPEAL FROM THE SUPREME COURT OF VIRGINIA AND ON CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SIXTH CIRCUIT AND THE UNITED STATES COURT OF APPEALS FOR THE EIGHTH CIRCUIT

MOTION FOR LEAVE TO FILE BRIEF *AMICI CURIAE* AND ANNEXED BRIEF OF THE COMMITTEE FOR ABORTION RIGHTS AND AGAINST STERILIZATION ABUSE, THE NATIONAL BAR ASSOCIATION (WOMEN LAWYERS DIVISION), THE NATIONAL EMERGENCY CIVIL LIBERTIES COMMITTEE, THE NATIONAL LAWYERS GUILD, THE NATIONAL WOMEN'S HEALTH NETWORK, AND THE REPRODUCTIVE RIGHTS NATIONAL NETWORK

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AKRON CENTER FOR REPRODUCTIVE HEALTH, INC., et al.,
Plaintiffs-Petitioners,
—v.—
CITY OF AKRON, et al.,
Defendants-Respondents.

PLANNED PARENTHOOD ASSOCIATION OF KANSAS CITY, MISSOURI, INC., et al.,
Plaintiffs-Petitioners,
—v.—
JOHN L. ASHCROFT, ATTORNEY GENERAL OF THE STATE OF MISSOURI, et al.,
Defendants-Respondents.

JOHN L. ASHCROFT, ATTORNEY GENERAL OF THE STATE OF MISSOURI, et al.,
Defendants-Petitioners,
—v.—
PLANNED PARENTHOOD ASSOCIATION OF KANSAS CITY, MISSOURI, INC., et al.,
Plaintiffs-Respondents.

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Nos. 81-185, 81-746 and 81-1172,
81-1255 and 81-1623

In the
Supreme Court of the United States
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Chris Simopoulos, M.D., FACOG,
Defendant-Appellant
v.
Commonwealth of Virginia,
State-Appellee

City of Akron, et al.,
Defendants-Petitioners,
v.
Akron Center for Reproductive Health,
Inc., et. al.,
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v.
City of Akron, et al.,
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Planned Parenthood Association of
Kansas City, Missouri, Inc., et. al.,
Plaintiffs-Petitioners
v.
John L. Ashcroft, Attorney General
of the State of Missouri, et al.,
Defendants-Respondents

John L. Ashcroft, Attorney General of
the State of Missouri, et al.,
Defendants-Petitioners
v.
Planned Parenthood Association of
Kansas City, Missouri, Inc., et al.,
Plaintiffs-Respondents

On Appeal from the Supreme Court of Virginia and on Certiorari to the United States Court of Appeals for the Sixth Circuit and the United States Court of Appeals for the Eighth Circuit

MOTION FOR LEAVE TO FILE BRIEF AMICI CURIAE OF THE COMMITTEE FOR ABORTION RIGHTS AND AGAINST STERILIZATION ABUSE, THE NATIONAL BAR ASSOCIATION (WOMEN LAWYERS DIVISION), THE NATIONAL EMERGENCY CIVIL LIBERTIES COMMITTEE, THE NATIONAL LAWYERS GUILD, THE NATIONAL WOMEN'S HEALTH NETWORK, AND THE REPRODUCTIVE RIGHTS NATIONAL NETWORK

The undersigned, as counsel for the Committee for Abortion Rights and Against Sterilization Abuse (CARASA), The National Bar Association (Women Lawyers Division), The National Emergency Civil Liberties Committee (ECLC), The National Lawyers Guild, The National Women's Health Network, and The Reproductive Rights National Network, respectfully move this Court for leave to file the accompanying brief amici curiae.

Amici organizations have all been actively involved in representing the interests of women adversely affected by legal restrictions on access to safe abortion services. Amici organizations support rights of reproductive freedom, including the rights to choose parenthood, to obtain abortions and to be free from involuntary and coerced sterilization. Amici are particularly concerned that state action making abortion services expensive and inaccessible have a disporportionately harsh burden on poor, working and minority women.

THE COMMITTEE FOR ABORTION RIGHTS AND AGAINST STERILIZATION ABUSE (CARASA) was formed in 1977 in response to the reaction against gains that women achieved in relation to sex based equality and reproductive freedom. It was founded by concerned women, who feared that poor women's limited access to abortion and the easy availability of sterilization would increase the incidence of sterilization abuse.

CARASA has several hundred active members working in the community to educate and organize people, and in the legislature to assure access to abortion, freedom from involuntary sterilization and a decent quality of life in which people can raise their children.

THE NATIONAL BAR ASSOCIATION, WOMEN LAWYERS DIVISION, founded in 1925, is a professional membership organization which represents more than 13,000 Black attorneys, judges and law students. Its purposes include achieving equal opportunities for minorities in the legal profession and protecting the civil and political rights of all citizens. To effectuate its goal of racial and sexual equality, the National Bar Association, through its Women's Division, has been actively involved in issues concerning child abuse and reproductive freedom.

THE NATIONAL EMERGENCY CIVIL LIBERTIES COMMITTEE ("ECLC") is a not-for-profit organization dedicated to the defense of the Bill of Rights and its extension to all our people -- particularly the poor and the powerless. Founded in 1951, the organization has worked to achieve these goals through litigation and public education. Among the cases it has sponsored in this Court are Kent v. Dulles, 357 U.S. 116, Kleindienst v. Mandel, 408 U.S. 753, and Law Students Civil Rights Research Council, Inc. v. Wadmond, 401 U.S. 154. Through similar means, it has sought to protect the right of reproductive freedom and the right to equal protection of the law at issue in this case.

THE NATIONAL LAWYERS GUILD ("NLG") is an organization of 7,000 lawyers, law students and legal workers dedicated to the goal of full equality for all people. Since its inception in 1937, the NLG has worked consistently for the advancement of the rights of poor and working people, racial minorities and women.

In the past decade, its work to support the women's movement has become an organizational priority. The National Lawyers Guild, a founding member of the Reproductive Rights

National Network, is actively involved in protection of reproductive rights for poor, minority and working women. Individual NLG members, in cases brought throughout the nation, represent litigants seeking to prevent cutbacks in abortion funding or attempting to end sterilization abuse.

THE NATIONAL WOMEN'S HEALTH NETWORK is a national consumer organization which focuses on women's health. It has 10,000 individual members and, in addition, 300 organizational members including health centers, consumer groups and women's health organizations. It is the only national consumer organization focusing on a broad range of women's health issues.

THE REPRODUCTIVE RIGHTS NATIONAL NETWORK is a national organization working to defend abortion rights, end sterilization abuse, reduce infant mortality, assure adequate childcare services, and promote lesbian rights. More than 80 organizations participate in the NETWORK, doing activist work on reproductive health issues from a feminist prospective.

The annexed brief argues that Commonwealth of Virginia, the City of Akron, and the State of Missouri violate the constitutional rights of women by placing onerous and wholly unjustified restrictions on access to abortion. Because these restrictive laws are premised upon and perpetuate inaccurate stereotypes about the incompetence of women, the constitutional guarantee of sex based equality, as well as the constitutional right to privacy recognized in Roe v. Wade, compell invalidation of the challenged provisions.

We have sought the consent of the parties to file this brief amici curiae. Counsel for all parties in all three cases have consented, with the exception of counsel for the Commonwealth of Virginia in Simopoulos v. Virginia (No. 81-185).

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On Appeal from the Supreme Court of Virginia
and on Certiorari to the United States Court
of Appeals for the Sixth Circuit and the
United States Court of Appeals for the
Eighth Circuit

BRIEF AMICI CURIAE OF THE COMMITTEE FOR ABORTION RIGHTS AND AGAINST STERILIZATION ABUSE, THE NATIONAL BAR ASSOCIATION (WOMEN LAWYERS DIVISION), THE NATIONAL EMERGENCY CIVIL LIBERTIES COMMITTEE, THE NATIONAL LAWYERS GUILD, THE NATIONAL WOMEN'S HEALTH NETWORK, AND THE REPRODUCTIVE RIGHTS NATIONAL NETWORK

This brief is submitted by the undersigned amici curiae conditionally upon the granting of the motion for leave to file to which it is attached.

INTEREST OF AMICI

The interest of the amici is set forth in the attached motion for leave to file.

SUMMARY OF ARGUMENT

Until quite recently, the law sharply restricted the opportunities of women in wage work and public life. A central justification for such laws was to protect and maintain women in their biologically ordained role as mothers. Since 1971 this Court has repeatedly affirmed that gender based laws "must carry the burden of showing an 'exceedingly persuasive justification'. . ." Miss. Univ. for Women v. Hogan, 50 U.S.L.W. 5068, 5070 (1982).

State action restricting access to abortion imposes onerous costs upon women. In the guise of protecting women, such laws compel an enormous sacrifice of women's physical integrity and personal autonomy.

The laws challenged in these cases require that physicians abandon standard medical practice and considered professional judgment; criminal penalties enforce compliance. In the many areas where hospitals are inaccessible to physicians providing abortions, the effect of the "protective" hospitalization requirement is to force the woman to endure an unwanted pregnancy. Similarly, the mandatory "informed" consent and waiting period requirements exact high costs from women and physicians, solely to perpetuate the inaccurate stereotype of the woman as incapable of moral and practical decisionmaking, and to force her to accept her maternal destiny.

ARGUMENT

I. Historically Differences in Reproductive Capacity of Men and Women Have Provided A Primary Justification for Laws Creating a Separate, Inferior Status for Women.

Since 1971 this Court has repeatedly recognized that "legislative classifications which distribute benefits and burdens on the basis of gender carry the inherent risk of reinforcing the stereotypes about the 'proper place' of women and their need for special protection." Orr v. Orr, 440 U.S. 268, 283 (1979). Laws premised on stereotypes about men and women are destructive, and constitutionally infirm, not only because they hurt individual men and women who do not fit the stereotype, but also because they are self-fullfilling. As the Court stated, in striking down the Utah law requiring that parents support their male children until age 21 and their female children only until age 18:

> No longer is the female destined solely for the home and the rearing of the family, and only the male for the marketplace and the world of ideas. . .If the female is not to be supported so long as the male, she hardly can be expected to attend school as long as he does, and bringing her education to an end earlier coincides with the role-typing

> society has long imposed.
> Stanton v. Stanton, 421 U.S. 7, 14-15 (1975).

Only last term, this Court eloquently reaffirmed that "the party seeking to uphold a statute that classifies individuals on the basis of their gender must carry the burden of showing an 'exceedingly persuasive justification' for the classification." Miss. Univ. for Women v. Hogan, 50 U.S.L.W. 5068, 5070 (1982).

The Court and the country have not always been sensitive to the oppression of sex based discrimination. "There can be no doubt that our Nation has had a long and unfortunate history of sex discrimination." Frontiero v. Richardson, 411 U.S. 677, 684 (1973). There is also no doubt that this unfortunate history of sex discrimination was primarily justified by the differences in reproductive capacity of men and women. The biological fact that women are capable of bearing children has been used to legitimate legislation creating a separate system of rights and responsibilities for women, and judicial approval of laws to "protect" and maintain women in their biologically ordained role as mothers.

This Court's approval of separate spheres for men and women based on women's reproductive capacity was first set forth in Bradwell v. Illinois, 83 U.S. (16 Wall) 130 (1873). Myra Bradwell had met all the qualifications to become a member of the Illinois bar except for one - she was not a male. The Court faced the question whether a state could deny her the occupation of her choice solely because she was female and answered that it could. Justice Bradley's concurrance is the classic statement of the 19th century view of women's place in this society:

> ...the civil law, as well as nature herself, has always recognized a wide difference in the respective spheres and destinies of man and woman. Man is, or should be, woman's protector and defender. The natural and proper timidity and delicacy which belongs to the female sex evidently unfits it for many of the occupations of civil life. The constitution of the family organization, which is founded in the divine ordinance as well as in the nature of things, indicates the domestic sphere as that which properly belongs to the domain and functions of womanhood ...

> The paramount destiny and mission of woman are to fulfill the noble and benign offices of wife and mother. This is the law of the creator. And the rules of civil society must be adopted to the general constitution of things ... Bradwell v. Illinois 83 U.S. (16 Wall) at 141.

This "noble and benign" mission of motherhood denied Myra Bradwell the right to practice law; Justice Bradley perceived it was "the law of the creator," not the state, which constructed this dual system of rights.

Bradwell was only the beginning of this Court's endorsement of discrimination against working women in the guise of protection. In Muller v. Oregon, 208 U.S. 412 (1908), this Court again viewed women's anatomy as destiny.

> That women's physical structure and the performance of maternal functions place her at a disadvantage in the struggle for subsistence is obvious. This is especially true when the burdens of motherhood are upon her. Even when they are not, by abundant testimony of the medical fraternity continuance for a long time on her feet at work, repeating this from day to day, tends to injurious effect upon the body, and as healthy mothers are essential to vigorous offspring, the physical well-being of women becomes an object of public interest and care in order to preserve the strength and vigor of the race. Muller, 208 U.S. at 421.

The need for a woman to "proper[ly] discharge her maternal function" justified the maximum hours law in Muller, 208 U.S. at 422, and other laws "protecting" women by limiting their employment opportunities[1] These laws helped create the sex segregated job market, with the more lucrative positions reserved for men.[2] By defining a job as requiring overtime, night work, or heavy lifting, employers could completely disqualify women. Maximum hour laws denied women higher paid overtime work. Finally forced maternity leaves denied women work and seniority.[3] These "protective" laws gave women the option of staying at home or taking employment in lower paid, less desirable jobs.

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[1] See Women's Bureau, U.S. Dep't. of Labor, Summary of State Labor Laws for Women (1969), reprinted in Hearings on S.J. Res. 61 Before the Subcomm. on Const. Amendments of the Senate Comm. on the Judiciary, 91st Cong., 2nd Sess. 729 (1970); Oldham, "Sex Discrimination and State Labor Laws," 44 Den. L.J. 344 (1967).

[2] See generally Blumrosen, "Wage Discrimination, Job Segregation and Women Workers," 6 Women's Rts. L. Rep. 19 (1979-80); Ross, Sex Segregation and "Protective" Labor Legislation, reprinted in Hearings on S.J. Res. 61 Before the Subcomm. on Const. Amendments of the Senate Comm. on the Judiciary, 91st Cong., 2nd Sess. 392 (1970). Furthermore, sex segregation in employment has not decreased and some indicators show it is actually increasing. See U.S. Comm'n on Civil Rights, Social Indicators of Equality for Minorities and Women (1978); U.S. Dept. of Labor, 1975 Handbook on Women Workers (1975).

Employment was only one of the areas in which courts used biological differences to sanction laws denying women the rights and responsibilities of male citizens. Women and the blind were given special "protection" by a Georgia statute requiring payment of a poll tax.[4] "In view of the burdens necessarily borne by them for the preservation of the race, the State reasonably may exempt them [women] from poll taxes." Breedlove v. Suttles, 302 U.S. 277, 282 (1937). Unlike the blind, however, women were only exempt if they did not register to vote. The statute alleviated the tax burden by discouraging women from participating in the political process.

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[3] See e.g. the policies struck down in Nashville Gas Co. Tenn. v. Satty, 434 U.S. 136 (1977); Cleveland Board of Education v. LaFleur, 414 U.S. 632 (1974).

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[4] The poll tax is now illegal by judicial decision, Harper v. Virginia State Brd. of Elections, 383 U.S. 663 (1976) and constitutional amendment, U.S. Const. amend XXIV.

Biology justified the exemption of women from jury duty. Finding that "woman is still regarded as the center of home and family life", this Court upheld a Florida statute automatically excluding women from serving on juries unless they registered with the court clerk. Hoyt v. Florida, 368 U.S. 57, 62 (1961). As recently as 1970 lower Federal courts upheld such exemptions. Following Hoyt, a Federal district court explained: "Granted that some women pursue business careers, the great majority constitute the heart of the home, where they are busily engaged in the 24 hour day task of producing and rearing children, providing a home for the entire family, and performing the daily household work ..." Leighton v. Goodman, 311 F. Supp 1181, 1183 (S.D.N.Y. 1970).

Woman's role as a potential childbearer and childrearer justified a separate set of rights and responsibilities. Women were seen primarily responsible in the private sphere of home and family, while men's responsibilities were in the public sphere. Biological differences have been used to perpetuate an invidious system of discrimination against women. Under the banner of "protection" the law has justified a dual system of rights which prevented women from equal access to and participation in the public sphere in the glorification of motherhood.

Today, however, this Court rejects laws that create separate spheres for men and women by firmly and repeatedly affirming the Constitutional right to sex based equality under the law. See, most recently, Mississippi University for Women v. Hogan, supra. Since 1973 this Court has also affirmed that the Constitutional right to privacy prevents the state from denying women, and their physicians, access to the safe and legal abortion services that are essential to women's capacity to live as free, equal and autonomous citizens. See e.g., Roe v. Wade, 410 U.S. 113 (1973); Planned Parenthood of Central Missouri v. Danforth, 428 U.S. 52 (1976).

II. Laws Restricting Access to Reproductive Health Services Impose Enormous and Disproportionate Burdens on Women.

Only women bear the physical burdens of pregnancy. These burdens range from minor discomfort to permanent damage to health to loss of life.[5] When the state acts to restrict access to reproductive health services pregnant women are compelled to endure this physical invasion and the physical, psychological, and socio-economic consequences of it.

The value which the common law and constitution attach to the individual's right to control his or her own body is so high that people are not generally required to reach out to aid another, even when it is possible to save another person from grave injury.[6/]

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[5] G. Bourne and D. Danforth, Pregnancy (rev. ed. 1975). For an excellent summary see Regan, "Rewriting Roe v. Wade," 77 Mich L. Rev. 1569, 1579-83 (1979).

[6/] W. Prosser, The Law of Torts §56 (4th ed. 1971) 340-341.

> Consider a simple burning building, with a child trapped inside. Would a court impose criminal liability on anyone, even the child's parent, who did not attempt to save the child at the risk of second-degree burns over one or two percent of his or her body? . . . (A)n innocent life can be saved by a physical invasion comparable to or less than pregnancy and delivery. . . (E)ven if the potential rescuer is specified to be the child's parent, liability is unlikely. In all other cases, the suggested imposition is unthinkable in the context of our legal system.

Regan, "Rewriting Roe v. Wade," supra n.5 at 1558.

Laws restricting access to abortion impose upon one class of people, women, uniquely onerous obligations to endure physical intrusion to aid another.[7] By restricting abortion and forcing a woman to carry a fetus to term, the state demands that women tolerate the most intrusive form of physical invasion of their bodies. The right to freedom from this type of physical intrusion has long been a part of our legal heritage:

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[7] It is not possible to say that a pregnant women voluntarily assumes a duty to aid the fetus. No method of contraception is entirely effective. The one year failure rates for various methods of contraception range from 2% for pills to 10% for diaphrams and condoms to 40% for douche. R. Hatcher, et. al. Contraceptive Technology, 1982-1983 (11th Rev. Ed. 1982).

An assertion that women, by engaging in sex, voluntarily assume a duty to aid the fetus depends on the archaic, reprehensible, and constitutionally indefensible notion that women, but not men, may be punished for their sexual activity, and punished by being forced to bear a child. Eisenstadt v. Baird, 405 U.S. 438 (1972); Carey v. Population Services Intl., 431 U.S. 678 (1977).

> No right is held more sacred, or is more carefully guarded, by the common law, than the right of every individual to the possession and control, of his own person ... Union Pacific Railway Co. 141 U.S. 250, 251 (1891).

Individual interests in freedom from state mandated intrusions on physical integrity are explicitly protected by the 13th Amendment's prohibition against involuntary servitude, the 8th Amendment's ban on cruel and unusual punishment, as well as the constitutionally protected right to privacy.[8]

The sexually differential impact of reproductive capacity is not limited to pregnancy itself. When reproductive health services are restricted, all heterosexually active women know that their life may be interrupted at any time by the short and long range risks and burdens of pregnancy.[9] This in turn profoundly affects the ability of women to plan their lives. By exacerbating this uncertainty, restrictions on reproductive health services pervasively undermine the ability of women to achieve and contribute in wage work and public life.

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[8] The constitutional right to privacy affirmed in Roe v. Wade has deep and strong historic roots. 410 U.S 113, 152 (1973). It prohibits laws restricting access to abortion, unless they are narrowly designed to serve compelling state purposes. This constitutional requirement is appropriately more rigorous than the heightened scrutiny demanded of ordinary sex based classifications; the enormity of the burdens that unwanted pregnancy imposes upon women and the centrality of control of reproductive capacity to women's equality as citizens, workers and human beings require no less.

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[9] In Michael M. v. Sonoma County, 450 U.S. 464, 471 (1981) this Court recognized that pregnant women and girls confront:

> problems more numerous and more severe than any faced by her male partner. She alone endures the medical risks of pregnancy or abortion. She suffers disproportionately the social, educational, and emotional consequences of pregnancy.

In that case the Court found that the sexually disproportionate burdens which unwanted pregnancy imposes on women are so severe that the rigorous equal protection standard had been met, even though the fit between the sex based classification defining the crime of statutory rape and the objective of avoiding unwanted pregnancy was extremely tenuous. Here by contrast there is a direct, demonstrable relationship between state created barriers to abortion and severe, predictable injury to women.

Technology sometimes allows human beings to transcend the limits of biology. We fly. We visit anartica and space. Advances in human understanding, science and medicine allow people greater control of reproductive capacity. When the state denies women access to reproductive health services, it is not nature, but the state, that prevents them from approaching the capacity for personal autonomy that has traditionally been the perogative of men.[10]

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[10] Kenneth Karst, "Forward: Equal Citizenship Under the Fourteenth Amendment," 91 Harv. L. Rev. 1, 57, n.320 (1978) notes, "Only a lawyer (a male lawyer) could regard . . . laws (regulating pregnancy, abortion and contraception) as sex neutral."

Laurence Tribe, American Constitutional Law, (1978) p. 924, observes:

> If a man is the involuntary source of a child-if he is forbidden, for example, to practice contraception-the violation of his personality is profound; the decision that one wants to engage in sexual intercourse but does not want to parent another human being may reflect the deepest of personal convictions. But if a woman is forced to bear a child-not simply to provide an ovum but to carry the child to term-the invasion is incalculably greater. Quite apart from the physical experience of pregnancy itself, an experience which of course has no analogue for the male, there is the

(Footnote continues on following page)

III. The Restrictive Abortion Regulations Challenged Here, Single Out Abortion From All Other Medical Services, Impose Requirements That Perpetuate Destructive, Inaccurate Stereotypes of Women, And Coerce Women to Accept Their Maternal Destiny.

The constitutionally protected right to privacy prevents the state from restricting access to abortion, prior to viability, unless the state demonstrates that restrictions are narrowly designed to serve compelling interests in the promotion of maternal health. Roe v. Wade, 410 U.S. at 162-63. The restrictive regulations challenged here are not justi-

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> attachment the experience creates, partly physiological and partly psychological, between mother and child. Thus it is difficult to imagine a clearer case of bodily intrusion, even if the original conception was in some sense voluntary.

fiable in relation to maternal health. Their purpose and effect is to demand the sacrifice of the health and well being of the woman.

All of the laws challenged in these three cases impose requirements for abortion that are very different from the legal restraint normally applicable to other medical procedures. For example the Akron and Missouri laws require that prescribed information be conveyed, that the women wait, 24 hours in Akron and 48 hours in Missouri, after receiving the required information, and that the information be communicated by the physician. These requirements, like all the restrictions challenged in these cases, are enforced by imposing criminal sanctions against the physician. These special requirements for abortion are all premised upon and perpetuate an inaccurate stereotype of women as incompetent, dependent upon male authority and incapable of moral decision making.

We support general requirements that written consent be obtained prior to any medical procedure, including abortion. Planned Parenthood v. Danforth, 428 U.S. 52, 65-67 (1976). Tort law requires consent prior to medical treatment, and, in most jurisdictions demands that the physician provide that information which a reasonably prudent person would want in deciding whether to undergo the proposed treatment. See e.g. Canterbury

v. Spence, 464 F.2d 772 (D.C. Cir.), cert denied, 409 U.S. 1064 (1972). At the heart of the informed consent requirement is the recognition, eloquently expressed by Benjamin Cardozo in 1914, that "every human being of adult years and sound mind has a right to determine what shall be done with his own body." Schloendorff v. Society of New York Hospital, 211 N.Y. 125, 129, 105 N.E.2d 92, 93 (1914). In 1976 Ohio codified the common law informed consent requirement, providing immunity from civil liability to doctors who use a consent form setting:

> forth in general terms the nature and purpose of the procedure, together with known risks, if any, of death, brain damage, quadriplegia, paraplegia, the loss of function of any organ or limb, or disfiguring scars

> associated with such procedures, with the probability of each such risk if reasonably determinable.

The general Ohio consent law also requires acknowledgment "that all questions asked about the procedure have been answered in a satisfactory manner." Ohio Rev. Code Ann. §2317.54 (1976). Consent to treatment is presumed to be legally valid if it meets these general requirements.[11]

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[11] Missouri common law requires that ". . . the patient is entitled to such information as he needs to make an intelligent decision and to give an informed intelligent consent." Roberson v. Menorah Medical Center, 588 S.W.2d 134, 137 (Mo. Sup. Ct. 1979). Doctors must provide such information as other physicians convey in comparable situations. Aiken v. Cleary, 396 S.W.2d 668, 674 (Mo. Sup. Ct. 1965).

The special abortion consent laws are constitutionally objectionable in that the explicit information required to be conveyed assume and perpetuate an inaccurate stereotype of women as incapable of moral decision-making. The Akron ordinance demands that she be told "that the unborn child is a human life from the moment of conception," and Missouri requires that she be informed of the "anatomical and physiological characteristics of the unborn child." A woman who experiences an unwanted pregnancy must make a decision. A woman who believes she is pregnant does not seek abortion services from a clinic or private physician, until and unless she makes a moral and personal choice to terminate the pregnancy. The decision normally proceeds action to effectuate it.[12/]

[12/] The trial court in Missouri found as a matter of fact on the basis of expert testimony "that, as a general proposition, women seeking abortions have completely thought out the abortion decision prior to approaching a clinic or personal doctor." Planned Parenthood Ass'n of Kansas City v. Ashrcoft, 483 F. Supp. 679, 696 (W.D. Mo. 1980)

Most abortions are provided in a relatively small number of large facilities. In 1980, 76% of abortions were performed in clinics serving 1000 or more abortion patient during the year. S. Henshaw, et. al., "Abortion Services in the United States, 1979 and 1980," 14 Family Planning Perspectives 5, 10 (1982). The most common reason women offer for the decision to have an abortion is that they "would not be able to give a child a fair chance at this time." This was cited by over 80% of women seeking abortions. L. Shusterman, "Predicting the Psychological Consequences of Abortion," 13A Soc. Sci. & Med. 683, 686 (1979).

This Court recognized in Roe v. Wade that "those trained in the respective disciplines of medicine, philosophy, and theology are unable to arrive at any consensus," as to when human life begins, and that there is a "wide divergence of thinking on this most sensitive and difficult question." 410 U.S. 160-61. These laws reflect a false and demeaning presumption that the state and the physician are more competent to make this moral decision than is the woman.

The laws also reflect an inaccurate stereotype of women as incompetent to make practical choices. Akron commands the physician to inform the woman that "numerous public and private agencies and services are available to assist her during the pregnancy and after the birth of her child," and Missouri law requires that she be given a list of such services. The physician and the state are not in a better position than the woman to evaluate the "public and private agencies and services" available to help her if she should bear a child.[13] As Justice Stevens observed, in discussing parental involvement in a minor's decision making, "the most significant consequences of the decision are not medical in character. . ." Bellotti v. Baird, 428 U.S. 132, 103 (1976). The abortion decision is profoundly moral and personal, as well as medical. The special consent laws for abortion both reflect the stereotype of woman as incapable of making significant life choices and attempt to force her to fulfill the "noble and benign" mission of motherhood.

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[13] The reality is that for many women the birth of a child condemns them to continued, desperate poverty. The American Promise: Equal Justice and Economic Opportunity, the Final Report of the National Advisory Council on Economic Opportunity (1981) documents that during the 1970's "more of the poor were women, and more women, especially those heading families with minor children, became poor." Inadequate public and private support services impose an "unusual amount of stress" on poor women that "exacts a toll on their physical and emotional health." Id. at p. 7.

The informed consent provisions do not treat the woman as a human being with a "right to determine what shall be done with her own body," but rather as confused and disoriented.

The ordinance requires that the doctor inform her that abortion "may leave unaffected" any psychological problems she may have. A law requiring the communication of information as self-evident and frivolous as this does not treat the woman as a competent person.

The requirements that the women wait, 24 hours in Akron and 48 hours in Missouri, after receiving the prescribed information ratify archaic stereotypes about the changability and indecisiveness of women. The trial courts below found that the waiting period "requires the patient to make two trips to the clinic instead of one," with attendant increases in travel, child care, and work loss expenses.[14] As the Circuit Court recognized in the Akron case, the "unstated" purpose of the mandatory waiting period is "to require a 'cooling off period' during which second thoughts might come into play." 651 F.2d at 1208.

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[14] Akron Ctr. for Reproductive Health v. City of Akron, 479 F. Supp. 1172, 1204-05; the waiting period "has, in fact, a detrimental effect on the health interests of women seeking abortions and . . . is unduly burdensome. . . " Planned Parenthood Ass'n of Kansas City v. Ashcroft, 483 F. Supp 679, 696. All the Circuit Courts that have considered fixed mandatory waiting periods after counseling and before abortion have found no medical justification for the inflexible waiting requirement. See Akron Center, 651 F.2d at 1208; Ashcroft, 655 F.2d 848, 866; Charles v. Carey, 627 F.2d 722, 785-86 (7th Cir. 1980); Planned Parenthood League of Mass. v. Bellotti, 641 F.2d 1006, 1014-16 (1st Cir. 1981).

As we have noted, the abortion decision normally proceeds action seeking an abortion. What then is the purpose of singling out this service, and demanding that women "think twice "? The waiting period embodies and perpetuates the classic stereotype of the changeable woman.[15/] The waiting period exacts substantial costs in terms of time, convenience, travel, and money; it inevitably in-

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[15/] Virgil tells us "A woman is always a fickle, unstable thing." Francis I of France explains, "Woman often changes; foolish the man who trusts her." The poet, Aaron Hill says, "First, then, a woman will or won't, depend on it." Alexander Pope opinioned, "Women's at best a contradiction still." J. Bartlett, Familiar Quotations, pp. 118, 400, 407 (14th ed. 1968.)

creases medical risk. A law causing concrete harm to women and supported by nothing but sex based stereotypes cannot stand. Stanton v. Stanton, supra; Orr v. Orr, supra; Mississippi University for Women v. Hogan, supra.

The requirement of the Akron and Missouri laws that the physician personally communicate this prescribed information is also demeaning to the woman. As we have seen, some of the information required is trivial or untrue; much of it does not relate to medicine or physical or emotional health, but rather to misplaced moral and social concerns. A law denying the physician's normal authority to delegate educational and communication tasks to others increases the cost of the abortion. It has no effect other than to restrict access to abortion and to deny the decision making competence of the woman patient.

Finally, the restrictive laws challenged in these three cases impose criminal penalties upon physicians who fail to comply with their mandate. Ordinary tort principles of informed consent treat the doctor/patient relationship as a private one; the doctor's superior knowledge, authority and skill give rise to the duty to provide information, but the law leaves enforcement of this duty to private agreement and civil action. Criminal sanctions provide special "protection" for women seeking abortions. As has so often been true of laws providing "special protection" for women, these policies reflect "an attitude of 'romantic paternalism' which, in practical effect, put women not on a pedestal but in cage." Frontiero v. Richardson, 411 U.S. 677, 684 (1973). Doctors who do not wish to confront the Hobson's choice of either personally communicating information they believe to be false or risking punishment as criminals can simply abstain from performing abortions. The shortage, in many areas total unavailability, of physicians willing and able to perform abortions is exacerbated.[16/] In the name of providing women "special protection" from uninformed decision-making, these laws create often insurmountable obstacles to effectuation of the women's choice. Laws mandating criminal punishment for doctors who fail to communicate information that many might reasonably believe to be false impermissibly "confine the attending physician in an undesired and uncom-

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[16/] In 1980, 78% of all U.S. counties had no identified provider of abortion services. S. Henshaw, "Abortion Services in the United States, 1979 and 1980," 14 Family Planning Perspectives 5, 5 (1982). Only about 10% of obstertrician-gynecologists in private practice perform abortions in their offices. Id. at 12. Only 17% of public hospitals and 34% of private, general non-Catholic hospitals reported any abortions performed in 1980. Id. at 11.

fortable straightjacket in the practice of his profession." Planned Parenthood v. Danforth, 428 U.S. 52, 67, n. 8 (1976).

Each of these three cases also challenges the requirement that abortions performed after the 12th week of pregnancy be done in the hospital. In every other medical situation, competent adults, in consultation with their physicians are free from state constraint in choosing whether medical treatment requires hospitalization.[17/] The physician and patient choice whether or not to use hospital facilities is influenced by medical

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[17/] See generally Curran and Shapiro, Law, Medicine and Forensic Science, Ch. 5 and 6 (1982).

factors, personal convenience, the availability of hospital facilities, and cost. In no other situation does the state demand that medical treatment be restricted to the hospital. Forcing women seeking abortions to use hospital facilities again reflects and reinforces the stereotype of women as incompetent, and in need of uniquely special state "protection."

The second trimester hospitalization requirement plainly has the practical effect of putting women, "not on a pedestal, but in a cage." Frontiero v. Richardson, 411 U.S. 677, 684 (1973). The evidence presented in each of these cases, confirms general data, showing that in most areas of the country there are no hospitals in which second trimester abortions may be performed.[18/] So, in the name of "protecting" women from the dangers of out-patient abortions in the second trimester, these laws force women to travel to areas where hospitals are available or where doctors are legally free to exercise their own medical judgment that hospitalization is unnecessary. The "protection" of women imposes upon them enormous financial and emotional

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[18/] Supra n. 16. Among the seriously limited number of hospitals providing any abortion services, 30% allow abortions only to women at 10 or fewer weeks gestation. Only 21% of hospitals allowing abortions will do so after 14 weeks gestation. S. Henshaw, et. al. "Abortion Services in the United States, 1979 and 1980," 14 Family Planning Perspectives 5, 14-15 (1982).

costs, and increases risks to life and health as a result of the inevitable delay. Many women are unable to pay the price that the state exacts for their "protection," and will hence be forced to continue their pregnancy.

Because of our pervasive history of harming women through laws designed to provide them special protection, the Court has often held, and recently eloquently reaffirmed that if the objective of a law is to "'protect' members of one gender because they are presumed to suffer from an inherent handicap or to be innately inferior, the objective itself is illegitimate." Mississippi University for Women v. Hogan, 50 U.S.L.W. 5068, 5070 (1982). In a world in which no state "protects" its citizens from unwisely choosing outpatient medical services, the special "protection", which the second trimester requirements provide exclusively for women seeking abortions, reflect and reinforce the assumption that women are "innately inferior" in their capacity to make appropriate medical decisions, in consultation with their physician. The lack of medical justification for the flat requirement that second trimester abortions be performed in the hospital[19] simply confirms that the

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[19] Planned Parenthood, et. al. v. Ashcroft, 664 F.2d 687 (8th Cir. 1981) reviews the data and concludes that the hospitalization requirement for second trimester abortions under-

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purposes of these policies are to reinforce the stereotype of women as people who suffer from an "inherent handicap," and to force them to fulfill their "paramount destiny" as mothers.

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mines women's health interest. The Sixth Circuit in Akron Center, etc. v. City of Akron, 651 F.2d 1198, found that evidence established the safety of outpatient procedures in the second trimester, and that the hospitalization requirement placed a significant burden on access to abortion, but nonetheless believed that this Court's summary affirmance of Gary-Northwest Indiana Women's Services v. Bowen, 451 U.S. 934 (1981) precluded a finding that the burdensome requirement was unconstitutional. See also Margaret S. v. Edwards, 488 F.Supp. 181, 193 (E. D.La. 1980), striking a hospitalization requirement as detrimental to women's health.

CONCLUSION

For the reasons stated above, amici respectfully submit that the judgment of the Eighth Circuit Court of Appeals should be affirmed, the judgment of the Sixth Circuit Court of Appeals should be affirmed in all respects except its holding that the constitutionality of the hospitalization requirement was forclosed by this court, and the judgment of the Supreme Court of Virginia should be reversed.

Respectfully submitted,

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Amicus Brief

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IN THE

SUPREME COURT OF THE UNITED STATES

OCTOBER TERM 1981

No. 81-1255

PLANNED PARENTHOOD ASSOCIATION OF KANSAS CITY, MISSOURI, ET AL., PETITIONERS

vs.

JOHN ASHCROFT, ET AL., RESPONDENTS

No. 81-1623

JOHN ASHCROFT, ET AL., PETITIONERS

vs.

PLANNED PARENTHOOD ASSOCIATION OF KANSAS CITY, MISSOURI, ET AL., RESPONDENTS

PETITIONS FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE EIGHTH CIRCUIT

MOTION FOR LEAVE TO FILE BRIEF AMICUS CURIAE AND BRIEF AMICUS CURIAE BY THE LEGAL DEFENSE FUND FOR UNBORN CHILDREN

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MOTION FOR LEAVE TO FILE BRIEF AMICUS CURIAE

The Court is moved for leave to file the attached brief amicus curiae by The Legal Defense Fund For Unborn Children.

The interest of the amicus is described in the attached brief.

The amicus curiae brief is not in support of either party. The purpose of the amicus is to defend the constitutional right to life of the unborn, which the parties have not done. The amicus demonstrates that the U.S. Supreme Court has already overruled Roe v Wade, 410 U.S. 113, and that mere argument that these killings can continue without question can be criminally prosecuted. The amicus addresses no arguments to the issues raised by the parties; but the facts and authorities presented by amicus dispose of all the issues raised by the parties.

Alan Ernest
Counsel for Amicus

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AMICUS CURIAE BRIEF BY THE LEGAL DEFENSE FUND FOR UNBORN CHILDREN

Interest Of Amicus Curiae

The Legal Defense Fund For Unborn Children is an organization whose purpose is to protect the constitutional rights of children unborn and born alive. The parties have not done this. This brief is not in support of either party.

Summary of Argument

The amicus curiae submits evidence not submitted by the parties, to show that Roe v. Wade is a mistake of law. The Roe v Wade killings violate the Fifth and Fourteenth Amendments of the U.S. Constitution. Any Justice who takes part in these killings can be criminally prosecuted. One of the giant homicidal frauds in the history of the world has been perpetrated on the American republic. The dagger of the assassin has been concealed beneath the robe of the jurist. This court has already overruled Roe v Wade, and must now do it expressly.

Argument

I. ROE v WADE IS BASED ON FALSE EVIDENCE, AND THE VICTIMS ARE BEING EXTERMINATED IN VIOLATION OF THE U.S. CONSTITUTION.

The evidence, summarized below, proves that the Court's conclusion in Roe v Wade, 410 U.S. 113, 158, "that the word 'person,' as used in the Fourteenth Amendment, does not include the unborn," is based on a fatal reversal of the burdens of proof and persuasion, and indispensable parts of the Court's evidence are fabricated and false. The evidence establishes, beyond the legal power of any federal judge to deny, that the unborn are persons whose lives are protected by the Fourteenth Amendment, as follows:

A.

Even the Court admitted in Roe v Wade, 410 U.S. at 156-157, that if the unborn were "a 'person' within the language and meaning of the Fourteenth Amendment," then the case for a constitutional right to kill the unborn, as claimed in Roe v Wade, "of course collapses, for the fetus' right to life would then be guaranteed specifically by the Amendment."

B.

The terms of the Fourteenth Amendment ("nor shall any state deprive any person of life ... without due process of law")(emphasis added) are "universal in their application." Yick Wo v. Hopkins, 118 U.S. 356, 369 (1886). The words "any person" admit of no exceptions whatever. Thus, on their face, the words "any person" include the unborn, as everyone else.

C.

The holdings of Chief Justice Marshall show that the Supreme Court had no lawful power to construe an exception to express, universal terms (such as "any person") unless the Court can show that "the absurdity and injustice of applying the provision to the case, would be so monstrous, that all mankind would, without hesitation, unite in rejecting the application."[1] And the Court must further prove that "had this particular case been suggested " to the framers, "the language would have been so varied as to exclude it."[2]

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[1] Sturges v Crowninshield, 4 Wheat. 122,202-3.

[2] Dartmouth College v Woodward, 4 Wheat.518,644-5.

Chief Justice Marshall founded the universality of the Supreme Court's jurisdiction on these very rules. [3/]

The Court thus bore a very extraordinary evidentiary burden before it could create an exception to the universal terms "any person" so that victims could be killed in violation of positive criminal statutes.[4/]

[3./] Cohen v Virginia, 6 Wheat. 264, 378-380.

[4./] The truth of this extraordinary evidentiary burden can be demonstrated by applying it to various cases. Before the Court could create an exception to the universal terms "any person" so that Jews, or Catholics, or the insane, could be killed like the unborn, the Court would have to demonstrate that "the absurdity and injustice of applying the provision [the terms- "any person"] to the case [the case of - Jews, Catholics, or the insane;,would be so monstrous, that all mankind would, without hesitation, unite in rejecting the application." Sturges v. Crowninshield, supra. And the Court must prove that if the case of the Jew, Catholic, or the insane had been suggested to the framers of the Fourteenth Amendment, then "the language would have been so varied, as to exclude it." Dartmouth College v. Woodward, supra. The framers would have changed the words of the Amendment to read that "No state shall deprive any person, except Jews, Catholics or the insane, of life ... without due process of law."

These same extraordinary evidentiary burdens must universally apply to all groups whose personhood may be challenged, including the unborn. Thus the Court bore the heaviest evidentiary burden possible in constitutional interpretation in order to create an exception to the universal terms "any person" so the unborn could be killed for any reason, or no reason, in violation of positive criminal statutes.

D.

The Supreme Court presented false evidence in Roe v Wade to support its conclusion that "the word 'person,' as used in the Fourteenth Amendment, does not include the unborn." Roe v Wade, 410 U.S. at 158. And, but for the false evidence, there is not even a credible foundation, much less a compelling one, for denying the protection of the express, universal terms "any person" to the life of the unborn.[5]

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[5] Summary of False Evidence:

In introduction, at the time the Fourteenth Amendment was adopted in 1868, most states had already enacted positive statutes that made abortion a crime unless it were necessary to save the life of the mother. Within a few years, these criminal abortion statutes were virtually universal.

Consequently, any theory of a constitutional right to abortion on demand faced an impossible contradiction: How is it possible that the people who adopted the Fourteenth Amendment had enacted positive criminal statutes to protect unborn life, but, at the same time, without a single word of explanation, intended to imply an exception to the express, universal terms that not "any person" can be deprived of life without due process of law, and to create a constitutional right to kill the unborn?

To resolve that fatal contradiction, the Court asserted the hypothesis that when the criminal abortion statutes were first enacted, the laws were not intended to protect unborn life, but rather were

E.

Not only are indispensable parts of the Supreme Court's evidence false, but the Court also fatally reversed the burdens

only intended to protect the mother. This hypothesis was falsely fabricated and used as follows:

A.

The Supreme Court first asserted, "When most criminal abortion laws were first enacted, the procedure was a hazardous one for the woman." Roe v Wade, 410 U.S. at 148. This was asserted as fact.

The only authority cited by the Supreme Court to prove this assertion of fact was a 20th century medical history book, Haagensen and Lloyd, A Hundred Years of Medicine 19 (1943), cited in Roe v Wade, supra, at 148n.43. But this book merely described the hazards of major surgery in general prior to Lister's discovery of antiseptics. The reference did not even mention the abortion operation.

However, the 19th century obstetric authorities throughout the Western world prove the Court's assertion of fact to be false. These 19th century obstetric authorities, based upon their own experience in performing abortions, and from hundreds of cases reported from around the world, declared in their obstetric textbooks that the abortion operation, the operation of artificially evacuating the fetus from the womb, was "perfectly safe" to the mother, 2 T. Denman, M.D., An Introduction to the Practice of Midwifery 96 (1802)(English physician); or "experience has proved that the dangers of the operation are reduced to a small matter," A.L.M. Velpeau, M.D., A Complete Treatise on Midwifery 530 (4th Am. ed. 1852)(French physician); or "to the mother there is very little danger." H.L. Hodge, M.D., The Principles and Practice of Obstetrics 293 (1864)(American physician). In short, the 19th century obstetric authorities prove the Supreme Court's assertion of fact to be false.

of proof and persuasion, as set out in the holdings of Chief Justice John Marshall. See pages 3-4, supra. Instead of the burden of

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The Supreme Court never revealed the "hazardous" abortion "procedure" to which it was referring. Actually, the 19th century physicians used the ancient method: "the membranes of the ovum are punctured," which permitted "the discharge of the waters," which induced the "action of the uterus" to "come on," which resulted in the expulsion of the fetus from the womb. 2 Denman, supra, 99. One 19th century physician traced this operation back almost 2000 years. F. Ramsbotham, M.D., The Principles and Practice of Obstetric Medicine 724 (4th ed. 1856).

Consequently, the 19th century physicians were using an ancient abortion operation which they described as not hazardous to the woman. The Supreme Court did not examine even one 19th century obstetric textbook. And the medical textbooks prove its assertion of fact, "When most criminal laws were first enacted, the procedure was a hazardous one for the woman," to be false.

B.

The Supreme Court next asserted, "Abortion mortality was high." Roe v Wade, 410 U.S. at 149. This is asserted as fact.

The Supreme Court asserted "Abortion mortality was high," without any authority to support it. It was a naked assertion. The 19th century obstetric authorities also prove this assertion of fact to be false. The medical authorities, supra, expressly asserted that the abortion operation was not deemed to be hazardous to the mother.

Consequently, the Court's assertion that "Abortion mortality was high" is false.

C.

Upon the two false assertions of fact, the Court falsely infers that "a State's real concern in enacting a criminal abortion law was to protect the proving that including the unborn within the terms "any person" would "be so monstrous, that all mankind would, without hesitation, unite in rejecting the application," the

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pregnant woman, that is, to restrain her from submitting to a procedure that placed her life in serious jeopardy." Roe v Wade, 410 U.S. at 149. Thus a false inference was drawn from false facts.

D.

From the false inference that the criminal abortion laws were not intended to protect the lives of the unborn, the Court falsely inferred that, likewise, the framers of the Fourteenth Amendment did not intend it to protect the lives of the unborn, "that the word 'person,' as used in the Fourteenth Amendment, does not include the unborn." Roe v Wade, 410 U.S. at 158. This false conclusion is drawn from a false inference which is drawn from false facts.

Moreover, as independent corroboration of the purpose of the criminal abortion statutes to protect the unborn, 19th century authorities in criminal law, e.g., 2 Archbold, Archbold's Criminal Procedure, Pleading and Evidence 295 (6th ed. 1853); medical jurisprudence, e.g., F. Wharton and M. Stille, M.D., A Treatise on Medical Jurisprudence 339, 927(2d ed. 1860); medicine, e.g., 12 Transactions of the American Medical Association 27-28(1860); as well as state supreme courts, e.g., State v Moore, 25 Iowa 128, 131, 135-36(1868), leave no doubt that these 19th century abortion laws were intended to protect the lives of the unborn. Consequently there is no other body of evidence to come to the Court's rescue.

CONCLUSION

The Supreme Court bore the burden of demonstrating, beyond a doubt based on reason, that the absurdity and injustice of including the unborn within the

U.S. Supreme Court fatally reversed the burden. The Court placed the burden on the unborn to prove with "assurance" (that is, to make certain and put beyond doubt) that they were persons within the terms "any person," or the unborn would be excluded from the terms "any person." Rather the burden was on the Supreme Court to prove

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terms "any person" would be "so monstrous, that all mankind would, without hesitation, unite in rejecting the application," Sturges v Crowninshield, supra. And the Court had to prove to a demonstration that if the case of the unborn had been presented to the framers and adopters of the Fourteenth Amendment, "the language would have been so varied as to exclude it." Dartmouth College v Woodward, supra.

But, the Supreme Court did not cite even one single 19th century authority that expressly agreed with its conclusion that "the word 'person,' as used in the Fourteenth Amendment, does not include the unborn," much less one that asserted that there was a constitutional right to kill the unborn, as set out in Roe v Wade. And the court's assertion that the 19tn century abortion laws were not intended to protect the lives of the unborn is shown to rest on false evidence.

The legal history demonstrates that the people who framed and adopted the Fourteenth Amendment not only intended it to protect the lives of the unborn, but these people had already enacted criminal abortion laws to do so in fact. This case for the unborn is absolutely conclusive. The terms "any person" must include the unborn.

with "assurance" that the unborn were not included within the terms "any person" or they would be included.[6/] And the evidence for the unborn is far stronger than that for many groups which the Court has judicially recognized to be included within the uni-

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6./ The Court illegally switched the burdens of proof and persuasion in the following manner. The Court first decreed a constitutional right to kill the unborn. Roe v Wade, 410 U.S. at 153. Incredibly, subsequently, the Court examined the question of the personhood of the unborn under the Fourteenth Amendment. Thus, in accordance with its compelling state interest test, once the constitutional right to kill the unborn was established, the burden was on the unborn to demonstrate the compelling justification of the criminal abortion statutes; that is, the burden was on the unborn to affirmatively prove that they were persons within the meaning of the terms "any person" in the Fourteenth Amendment- or be excluded.

Moreover, the objections which the Court raised to defeat the personhood of the unborn in Roe v Wade, 410 U.S. at 156-158 were either false, or irrelevant. This evidence will be submitted to the Court on request. The Court exactly perceived its function as that of a criminal defense lawyer who only has to raise doubts about the prosecution case to win. But the Court cannot exclude anyone from the protection of the words "any person" by merely working up quibbles or "inconsistencies." Roe v Wade, supra, 158 n.54.

Could the Court first decree a constitutional right to kill Jews? And then place the burden on the Jews to affirmatively prove that they are included within the terms "any person"? And then, by quibbling with the Jews' evidence, decide the Jews were not included within the terms "any person" so they could be hauled off to the graveyard?

versal terms "any person." [7]

The Supreme Court has exactly defied the express words "any person" in the Constitution, and their spirit,[8] as well as the plain intention of the framers,[9] and condemned to death those victims whom the Constitution endeavors to preserve.

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[7] The Court was so certain that "corporations" were included within the terms "any person" that it forbade any oral argument to the contrary. Santa Clara v. So. Pac. RR, 118 U.S. 394,396. And the Court held that "strangers and aliens" were included within the terms "any person" by merely observing: "These terms are universal in their application." Yick Wo v Hopkins, supra, at 369.

[8] The uncontradicted scientific evidence in Roe v Wade showed that the unborn child "is alive," that the fetal heartbeat begins "pulsations at 24 days," and "brain waves have been noted at 43 days."

The Court itself has recognized that, while the Declaration of Independence is not law in itself, yet it is "the thought and the spirit, and it is always safe to read the letter of the Constitution in the spirit of the Declaration of Independence." Gulf, Colo. & S.Fe v Ellis, 165 U.S. 150, 159-160.

The undisputed scientific evidence proves that the unborn child has been "created" and thus endowed with an "unalienable" right to "life," and within the spirit of the terms "any person." The Court would amend the Declaration to read that "all men are created equal-except those created to die for the convenience of others."

[9] The evidence, supra page 5 n.5, shows that the adopters of the 14th Amendment not only intended the lives of the unborn to be protected by the terms "any person," but they had already enacted criminal abortion statutes to do so in fact.

II. THE U.S. SUPREME COURT HAS WILLFULLY USED UNCONSTITUTIONAL PROCEDURES TO EFFECT AND MAINTAIN THE ROE v WADE KILLINGS.

The Supreme Court willfully used unconstitutional procedures to effect the Roe v. Wade killings.[1/]

And the Supreme Court has subsequently decided many abortion cases on the merits, but willfully used unconstitutional procedures to maintain the killings, as follows:

1. The Supreme Court willfully refuses to

[1./] Counsel did not especially represent the unborn in the District Courts in Roe v Wade and Doe v Bolton. And the Supreme Court denied Bolton's request to allow counsel to represent the unborn in the Supreme Court. Thus, counsel did not represent the unborn at any stage of the original proceedings.

The question of the personhood of the unborn under the Fourteenth Amendment came up for the first time in the original proceedings after the cases reached the Supreme Court. Since no group had ever been excluded from the protection of the Fourteenth Amendment so they could be killed, the original parties had no notice of the kind of evidence, or the burdens of proof and persuasion the Court would deem determinative. The first time the parties understood this was when Roe v Wade issued, and the victims were condemned to death. But the Court had taken judicial notice of numerous facts and factors which the original parties had not seen, much less cross-examined in a judicial proceedings. An original party asked permission to cross-examine the Court's evidence. But the Supreme Court would not allow its evidence to be cross-examined.

allow retained(no cost to taxpayers)counsel to represent the victims being killed; [2]

2. The Supreme Court willfully refuses to allow the evidence in Roe v Wade, which it used to condemn the victims to death, to be cross-examined; [3]

3. The Supreme Court willfully refuses to allow evidence to be presented on behalf of the victims being killed to establish their right to life under the U.S. Constitution.[4]

The U.S. Supreme Court's own rulings on due process of law show these procedures to to be unconstitutional[5] and criminal.[6]

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[2] Some of these cases are: Colautti v Franklin, 58 L Ed 2d 596, motion to allow counsel represent unborn denied 57 L Ed 2d 1131(1978); Anders v Floyd, 59 L Ed 2d 442, motion to allow counsel represent unborn denied 58 L Ed 2d 235(1978); Bellotti v Baird, 61 L Ed 2d 797, motion to allow counsel represent unborn denied 59 L Ed 2d 29(1979); Ashcroft v Freiman, 59 L Ed 2d 630, motion to allow counsel to represent unborn denied 59 L Ed 2d 630(1979); United States v. Zbaraz, 65 L Ed 2d 831, motion to allow counsel represent unborn denied 62 L Ed 2d 665-6(1980); Harris v. McRae, 65 L Ed 2d 784, motion to allow counsel represent unborn denied 63 L Ed 2d 775(1980); H.L. v. Matheson, 67 L Ed 2d 388, motion to allow counsel represent unborn denied 64 L Ed 2d 234 (1980).

[3] Supra Note 2.

[4] Supra Note 2.

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[5] The U.S. Supreme Court has held that even in civil, non-judicial proceedings, where crucial deprivations are threatened, such as loss of welfare, due process guarantees (1) Notice; (2) the right to be heard and to present evidence; (3) the right to confront and cross-examine adverse evidence; (4) the right of representation by retained counsel; (5) the right of an independent decisionmaker; (6) the right to have a written statement by the decisionmaker of the evidence relied upon and the reasons for the determination. Goldberg v Kelly, 397 U.S. 254, 268-271(1970). In Re Gault, 387 U.S. 1(1967); Morrissey v. Brewer, 408 U.S. 471 (1972); Gagnon v Scarpelli, 411 U.S. 778 (1973); Viteck v Jones, 63 L Ed 2d 552 (1980). Since the unborn are being killed, there can be no question whatever that these elements of due process of law are guaranteed.

[6] The criminality of such process is evident. Could a judge use such procedures to legalize the killings of the insane, or Jews? These are effectively the same procedures cited by the Nuremberg Court in convicting the Nazi judges of criminal extermination. United States v Altstoetter(The Justice Case), 3 Trials of War Criminal Before the Nuernberg Military Tribunals 1046(1951).

Can it now be argued that a judge, who could not condemn even one Jew to death without counsel in a criminal case, could condemn all Jews in the United States to death without counsel by calling it a civil case and decreeing that the lives of Jews were not protected by the Constitution? A person cannot be deprived of life or liberty without due process of law, regardless of the description of the proceeding. The Constitution thus guarantees that any proceeding to determine if one is a person within the meaning of the Constitution must satisfy due process of law.

And any judge who willfully deprives any victims of constitutional rights under a guise of law can be criminally prosecuted. Imbler v. Pachtman, 424 U.S. 409 (1976).

III. THE U.S. SUPREME COURT HAS CONFESSED IN COURT TO GUILT OF CRIMINAL EXTERMINATION, INCLUDING MASS MURDER, AND THIS IS THE LEGAL EQUIVALENT OF THE EXPRESS OVERRULING OF ROE v WADE, 410 U.S. 113 (1973).

For the 72nd time, the U.S. Supreme Court is accused in its own court with criminally exterminating millions of lives in violation of the U.S. Constitution, and 18 USC 242.[1/]

For the 48th time, the U.S. Supreme Court is accused in its own court with mass murder in violation of state and federal statutes.[2/]

For about the 52nd time, the U.S. Supreme Court is accused in its own court with willfully using unconstitutional, criminal procedures to maintain the Roe v Wade killings. [3/]

But, year after year, the U.S. Supreme Court has not denied the charges, much less

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1./ Charges based on evidence, supra page 2.

2./ Charges based on evidence presented in MOTION TO ALLOW COUNSEL TO REPRESENT CHILDREN UNBORN AND BORN ALIVE, incorporated herein by reference.

3./ Charges based on evidence, supra page 12. The evidence makes it plain why the U.S. Supreme Court is willfully using unconstitutional procedures to maintain the killings. The evidence proves, beyond the power of any federal judge to deny, that the charges are true.

attempted to prove the charges to be false. This silence year after year in the face of accusation, while the victims are being killed, amounts to a confession in court that the charges are true.[4] This tacit admission that Roe v Wade is a mistake of law is the legal equivalent of the express overruling of Roe v Wade. Any judge or party who chooses to close his eyes on these

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4./Under "the tacit confession rule," McCormick on Evidence §§ 161, 270, failure to deny a charge is equivalent to a confession that the charge is true. 4 Wigmore, Evidence, §§ 1071-1072(Chadborn rev 1972). "Underlying the rule is the assumption that human nature prompts an innocent man to deny false accusations and consequently a failure to deny a particular accusation tends to prove belief in the truth of the accusation." McCormick, supra, §161. And the Supreme Court itself has consistently recognized this rule. "(T)he Court has consistently recognized that ... silence in the face of accusation is a relevant fact. .... Silence is often evidence of the most persuasive character." Baxter v Palmigiano, 425 U.S. 308, 319(1976). And the rule is ancient. As Socrates cross-examined at his trial over 2000 years ago, "you are silent and have nothing to say. But is this not rather disgraceful, and a very considerable proof of what I was saying." And again, "I may assume that your silence gives assent." Apology in Plato 41, 45 (Jowett trans. Classics Club 1942).

And concerning the Court's continuing silence year after year, "Silence gains more probative weight where it persists in the face of accusation, since it is assumed in such circumstances that the accused would be more likely than not to dispute an untrue accusation." United States v. Hale, 422 U.S. at 176.

unparalleled facts, and argues that the killings can continue without question, can be prosecuted for complicity in criminal extermination just as if he had encouraged the killings after Roe v Wade was expressly overruled.[5/]

[5./] The Supreme Court asserted to legalize killings which violated positive criminal statutes, including murder statutes. If Roe v Wade is a mistake of law, then all the killings since 1973 can be criminally prosecuted. The ex post facto provisions of the U.S. Constitution do not apply to judicial decision which are a mistake of law. Ross v Oregon, 227 U.S. 150(1913). The general rule is that mistake of law is no excuse for breaking the law. Perkins, Criminal Law 920(2d ed. 1969). The narrow exception of reasonable reliance on a court opinion thereafter determined to be a mistake of law does not apply to homicide cases. Model Penal Code, Tentative Draft No. 4, Comments § 2.04, page 138. In any event, "after a warning," such as given herein, a defendant can not claim his reliance was reasonable. Id., at 138. And one can be criminally implicated in homicide by mere words of encouragement while the victims are being killed. Lafave and Scott, Criminal Law §§ 61,64(1972).

To illustrate the true status of Roe v Wade, suppose that a lawyer had accused "the supreme judge" of Nazi Germany of mass murder 50 times in court, but each time "the supreme judge" listened in silence and did not deny the charge and prove it false, and just continued the killings. Would such judicial conduct have warranted people in arguing that the killings could continue without question? The Nuremberg Court answered that question. Such argument amounts to criminal complicity in extermination.

Roe v Wade has been overruled. In the face of these unparalleled facts, one must literally gamble life and liberty to support it. Many states still punish mass murder with the death penalty.

CONCLUSION

The Supreme Court has perpetrated one of the giant homicidal crimes in history on the United States. And the corruption of a judicial system for the accomplishment of criminal extermination involves an element of evil which is not found in frank atrocities which do not sully the judicial robes. The dagger of the assassin has been concealed beneath the robe of the jurist.

By its conduct, the U.S. Supreme Court has overruled Roe v Wade, 410 U.S. 113. Mere argument that the killings can continue can be criminally prosecuted. To save innocent lives from extermination, and uninformed persons from prosecution, the Supreme Court must expressly overrule Roe v Wade.

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Supplemental Brief

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IN THE
SUPREME COURT OF THE UNITED STATES
OCTOBER TERM 1981

JOHN ASHCROFT, ET AL, PETITIONERS

vs.

PLANNED PARENTHOOD ASSOCIATION OF KANSAS CITY, MISSOURI, ET AL., RESPONDENTS

No. 81-1623

PLANNED PARENTHOOD ASSOCIATION OF KANSAS CITY, MISSOURI, ET AL., PETITIONERS

vs.

JOHN ASHCORFT, ET AL., RESPONDENTS

PETITIONS FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE EIGHTH CIRCUIT

MOTION TO ALLOW COUNSEL TO REPRESENT CHILDREN UNBORN AND BORN ALIVE

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MOTION TO ALLOW COUNSEL TO REPRESENT CHILDREN UNBORN AND BORN ALIVE

The Court is moved to allow Alan Ernest to represent the victims being killed by Roe v Wade, 410 U.S. 113, as counsel or guardian ad litem.

Interest of Counsel

Alan Ernest is a lawyer in the District of Columbia and a member of the bar of this Court. His interest is to defend the constitutional right to life of the children unborn and born alive being killed pursuant to Roe v. Wade. The parties have not done this.

This is effectively a motion to allow retained counsel to represent the victims being killed, since there will be no expense to this Court, or to the taxpayers.

Summary of Argument

In Roe v Wade, the Court asserted to legalize killings which had been defined as murder since long before the adoption of the Fourteenth Amendment. Thus, Roe v Wade is no law at all, and should be expressly overruled.

This will dispose of all the issues raised by the parties.

The victims being killed are entitled by the U.S. Constitution to be especially represented by retained(no cost to taxpayers) counsel who has authority to cross-examine the evidence in Roe v Wade, which the Court used to condemn the victims to death, and to present evidence on their behalf to establish their right to life under the U.S. Constitution.

It can not be pretended that it is any longer the government of the United States, or any government of Constitution and laws, wherein judges Hitler-like assert to legalize mass murder, and then maintain the killings by willfully refusing to allow retained counsel to represent the victims being killed and defend their right to life protected by the Constitution.

The amicus curiae brief by the Legal Defense Fund For Unborn Children filed herein is incorporated by reference.

ARGUMENT

ROE v WADE IS NO LAW AT ALL, SINCE THE COURT HITLER-LIKE ASSERTED TO LEGALIZE KILLINGS DEFINED AS MURDER SINCE LONG BEFORE THE ADOPTION OF THE FOURTEENTH AMENDMENT

Counsel presents new evidence herein,[1] not presented by the parties, to show that many of the killings that the Supreme Court asser-

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[1] The new evidence was published in The Washington Post on September 12, 1979, under the caption "WASHINGTON LAWYER CHARGES U.S. SUPREME COURT WITH MASS MURDER," as set out below. That the charging evidence can be published in the dominant newspaper in the nation's capital, but, as the victims are being killed, the evidence can not even be heard in this Court, proves the complete criminal degeneracy of the judicial system. The newly discovered evidence shows the Court asserted to legalize killings defined as murder since before the adoption of the 14th Amendment.

SUMMARY OF ARGUMENT

MANY ROE v WADE KILLINGS ARE MURDER

The evidence shows that many of the killings permitted by Roe v Wade, 410 US 113(1973) were murder in 1868. Since the killings were murder in 1868, then absent a constitutional amendment, the killings are still murder, and Roe v Wade is not law at all.

ARGUMENT

1. Introduction to Evidence

The evidence presented herein shows that, at the time the Fourteenth Amendment was adopted in 1868, the unlawful killing, with malice aforethought, of a child born alive was murder. Killings of children born alive were not treated as a special category, as was abortion.

It is thus absolutely indispensable to examine what "born alive" meant in 1868. It is obvious that, if the life of a child born alive was protected by ted to legalize in Roe v Wade, 410 US 113, had thereto been defined as murder. It is just as if the Court asserted a right to kill Jews. Obviously, absent a constitutional amendment, these killings are still murder. Justices who have presumed to permit these killings may now be facing the death penalty in very many states.

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the murder laws in 1868, then it is a person within the language and meaning of the Fourteenth Amendment.

The evidence shows that in 1868, born alive did not mean natural birth after nine full months of gestation; nor did it mean birth after viability, "that is, potentially able to live outside the mother's womb, albeit with artificial aid." Roe v Wade, 410 US at 160. If abortion resulted in a live but unviable child that died as a consequence of its not being able to survive outside the womb, it was murder and punishable by the death penalty.

The evidence shows that the hysterotomy is a common method of performing abortions under Roe v Wade.This is essentially a Caesarean in which a live but unviable child is removed from the womb and left to die. The legal authorities show that in 1868, such a killing was murder, and punishable by the death sentence.

In summary, what was murder in 1868, can not now be decreed a constitutional right. Without an amendment to the Constitution, the killings must still be murder, and the Justices who permitted these killings may be guilty of mass murder in the first degree. This is still punishable by the death sentence in many states.

Many people would no doubt be astonished to learn that the case presented herein for the unborn is the very case they would have to present for themselves if their right to life were challenged. For example, take almost any group of persons, such as the insane, invalids, Jews or Catholics. Suppose it were claimed in federal court that the

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2. The English Law

The English law, as reflected in the writings of Coke(3 Inst. 50), Hawkins(1 Hawkins Ch. 13, s. 16) and Blackstone(4 Bl. Com. 198) defined the felonious killing of a child "born alive" as murder, even if the child received the fatal wound in the womb.

These authorities were followed by the English courts in permitting prosecutions of the killings of children born alive as murder. Rex v Senior, 1 Moody CC 346 (1832); Reg. v Trilloe, 174 Eng. Rep. 674 (1842); Reg. v West, 2 C & K 784 (1848).

Most critically, in the English law, a child did not have to be viable to be born alive. In 1848, the leading case of Regina v West, 2 C & K 784, was decided. The indictment for murder alleged that the defendant had inserted a "certain pin" "upward into the womb " of a pregnant woman for the purpose of producing the abortion of a "quick" child; and that this resulted in the child being "prematurely born and brought forth alive from and out of the womb." Id., 784-85. The child died shortly thereafter. A "medical witness" had testified that:

"(I)t was a healthy child; but that, being born at that period of gestation, it was impossible that it could live any considerable length of time separated from the womb of the mother. It was incapable right of "privacy" announced in Roe v Wade includes the right to kill members of these groups, as well as the unborn. If the burden were suddenly thrust on these groups, as it was thrust on the unborn, to prove that they are persons whose lives are protected by the Fourteenth Amendment, what factual, non-argumentative evidence could they find to estab-

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of maintaining a separate and independent existence." Id., at 786.

The judge, relying on Coke and Blackstone, instructed the jury:

"The prisoner is charged with murder; and the means stated are, that the prisoner caused the premature delivery of the witness, Hensen, by using some instrument for the purpose of procuring abortion; and that the child so prematurely born was, in consequence of its premature birth, so weak that it died. .... I am of opinion(and I direct you in point of law), that if a person intending to procure abortion does an act which causes a child to be born so much earlier than the natural time, that it is born in a state much less capable of living, and afterwards dies in consequence of its exposure to the external world, the person who by her misconduct so brings the child into the world, and puts it thereby in a situation in which it cannot live, is guilty of murder." Id., at 788.

The case of Regina v West, supra, was presented by the leading English writers as the correct statement of the law of murder. See, e.g., 1 J.F. Archbold, A Complete Treatise on Criminal Procedure, Pleading and Evidence 783 (Waterman Am. ed. 7th ed. 1860); 1 W.O. Russell, A Treatise on Crimes and Misdemeanors 671-672 (4th ed. 1865); A.S. Taylor, A lish their right to life?

As the case of the unborn shows, it would do no good to object that no one ever heard of such a constitutional right to kill, or to object that such killings had thereto been defined as criminal. And the Fourteenth Amendment merely states that it pro-

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Manual of Medical Jurisprudence 516(Penrose Am. ed. 6th ed. 1866). Consequently, the abortion of a quick but unviable child that resulted in the child being born alive so prematurely that its death was caused by its inability to survive outside the womb, was murder.

3. The American Law Of Murder in 1868.

The English common law of murder of children born alive is significant since American courts used the English common law to construe their murder statutes. Clarke v State, 117 Ala. 1(1898); Hamilton v United States, 26 App. D.C. 382(1905).

American courts cited Coke, Hawkins, Blackstone, and the English court decisions, as authoritative definitions on the law of homicide of children born alive. See, e.g., Clarke v. State, 117 Ala. 1(1898); State v Winthrop, 43 Iowa 519(1876). By 1868, leading American legal authorities had specifically cited Regina v West, supra, as the correct law of murder of a child born alive. (As already noted, that case held that if a criminal abortion resulted in the premature delivery of a quick but unviable child that died after delivery as a consequence of its being so prematurely delivered that it could not survive outside the womb, it was murder.) See, e.g., F. Wharton, A Treatise on the Law of Homicide in the United States 96-97(1855). By 1868, this appears to be the uncontradicted view.

tects life of "any person." So, as with the unborn, the Amendment does not expressly refer to the insane, or invalids, or Jews, or Catholics; and its legislative history does not appear to specifically refer to any of these groups. As with the unborn, the murder laws do not expressly refer to the insane,

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Consequently, the evidence shows that the life of a quick but unviable child born alive was protected by the murder laws in 1868.

4. The Law Of Murder In 1868 And The Fourteenth Amendment

Since the evidence shows that the life of a quick but unviable child was protected by the murder laws in 1868, the evidence likewise establishes that the child so born alive is a person within the language and meaning of the Fourteenth Amendment.

By seizing upon viability, Roe v Wade permits the killings of quick but unviable children born alive. The Supreme Court presumed to decree the killings of these children to be a constitutional right without any examination whatever to see if these children were persons within the language and meaning of the Fourteenth Amendment. It is a naked decree without any investigation into the law of murder of children born alive.

This raises the question,- Does the Supreme Court have the Hitler-like power to decree murder to be a constitutional right? If invalids were protected by the murder laws in 1868, can the Supreme Court, without evidence or investigation, decree a constitutional right to kill invalids? If Jews were protected by the murder laws in 1868, can the Supreme Court decree, without evidence or investigation, a constitutional or invalids, or Jews, or Catholics; and their legislative histories, to the extent they have any, do not appear to specifically refer to any of these groups. The principle in the Declaration of Independence, that all people are "created" equal and endowed with an unalienable right to "life," having been

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right to kill Jews? If newspaper editors were protected by the murder laws in 1868, can the Supreme Court, without evidence or investigation, decree a constitutional right to kill newspaper editors?

No doubt the Supreme Court bears the burden of proving, by evidence so conclusive that it will not admit of a rational doubt, that it possesses the power to decree murder to be a constitutional right.

5. The Hysterotomy Abortion Under Roe v Wade

A common way to perform abortions under Roe v Wade is by hysterotomy. See, Commonwealth v. Edelin, 359 NE 2d 4(Mass. 1976). A hysterotomy is essentially a Caesarean, in which a live but unviable child is removed from the womb and left to die. 1 Hearings Before the Subcommittee On Civil And Constitutional Rights Of the Committee of the Judiciary, House of Representatives On Proposed Constitutional Amendments on Abortion 397 (94th Cong., 2nd Sess. 1976).

As established by medical testimony during the 1976 House Abortion Hearings, "With few exceptions, babies aborted by this method will all move, will all breathe, and some will cry .... Almost all were born alive." Id., at 397.

Consequently, by definition, in 1868, these hysterotomy abortions could have been prosecuted as murder.

sneered out of court in the unborn's case, now provides no assurance for anyone. So what factual, non-argumentative evidence is there for members of these groups to protect themselves from extermination?

The case presented herein for the unborn,

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6. Roe v Wade and Mistake of Law

The Supreme Court itself has recognized that constitutional provisions against ex post facto laws do not apply to judicial decisions that are a mistake of law. Ross v Oregon, 227 US 150(1913). Consequently, if Roe v Wade is a mistake of law, then mass murder is being perpetrated in America. The Roe v Wade hysterotomy killings, by definition under the common law, and thus constitutional law, violate the positive criminal murder statutes throughout the United States.

The killings of children born alive have been prosecuted as murder in the first degree, Comm. v Harmon, 4 Barr. 269 (Pa. 1846)(child thrown in creek); or murder in the second degree, Clarke v State, 117 Ala. 1 (1898)(wife beaten, child die from injuries); or manslaughter, People v Chavez, 77 Cal. App. 2d 621(1947)(child neglected),- according to the facts of the particular case, as in any other homicide.

In connection with these judicial killings, it is relevant to note that the Supreme Court decreed murder to be a constitutional right without any examination whatever of the law of murder of children born alive. And as Abraham Lincoln noted, "(I)t is an established maxim in morals that he who makes an assertion without knowing whether it is true or false, is guilty of falsehood; and the accidental truth of the assertion, does not justify or excuse him." 1 The Collected Works of Abraham Lincoln 384 (Basler ed. 1953). Since Lincoln's day, this "maxim in morals" supra note 1, is thus the case for everyone else. The common law is the dictionary; it has traditionally been used to define the terms of the homicide statutes. It is this same body of factual evidence upon which all groups must ultimately rely to establish

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has also been a textbook definition of perjury. See, 3 Wharton's Criminal Law and Procedure, § 1308, p. 673 (12th ed. 1957).

Consequently, rational people are entitled to believe, and a jury may be permitted to find, that the process by which the Supreme Court decreed murder to be a constitutional right is perjury or criminal fraud. It seems reasonable that such judicial killings, after such prolonged deliberation and adherence, could be prosecuted as murder in the first degree. Many states still punish mass murder in the first degree with the death sentence.

It may be that the judges responsible for the judicial killings did not believe that they were breaking the law. But, as Justice Oliver Wendell Holmes once wrote, "Ignorance of the law is no excuse for breaking it." "It is no doubt true that there are many cases in which the criminal could not have known that he was breaking the law, but ... the lawmaker has determined to make men know and obey." Holmes, The Common Law 41 (Howe ed. paperback 1963).

It now full well appears that the Justices of the Supreme Court of the United States have presumed to decree murder to be a constitutional right, without any evidence or examination whatsoever, with the death penalty the possible consequence of their decision being a mistake of law.

It now appears that, unless the Supreme Court can prove by evidence, beyond a doubt based on reason, that it has the Hitler-like power to decree mass their right to life. The evidence, supra n.1, conclusively proves that the Supreme Court has Hitler-like, that is, by naked decree without any investigation of the law of murder, asserted to legalize mass murder. Roe v Wade is a mistake of law, that is, no law at all. All the countless thousands of

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murder to be a constitutional right, then Roe v Wade is just such a mistake of law.

CONCLUSION

Is government of laws founded upon evidence, or the mere naked decrees of men holding office for life?

The evidence proffered herein would appear sufficient to permit reasonable people to conclude beyond a reasonable doubt that the Supreme Court of the United States has committed mass murder in the first degree. The evidence would appear sufficient for reasonable people to conclude that, upon a scale never seen before in the peacetime history of the world, "The dagger of the assassin was concealed beneath the robe of the jurist." The Justice Case, 3 Trials of War Criminals Before the Nuernberg Military Tribunals 985 (GPO 1951).

If the United States were being ruled over by a Tribunal of Murderers, holding office for life, nakedly decreeing mass murder to be a constitutional right, in open defiance of the evidence, and presuming to be blindly obeyed by all courts, executives, legislatures, and people whatever without question, regardless of the evidence, then surely it would be the most astounding event in the legal history of the human race.

born alive Roe v Wade killings since 1973 can be prosecuted as murder. Anyone who takes part in this national scheme of on-going killings in any intentional manner whatever, even by mere words of encouragement in Court, can be prosecuted for complicity in mass murder just as if Roe v Wade had never been decided. The Supreme Court is not above the law of murder. Roe v Wade is no law at all, and ought to be expressly overruled to reflect the true state of the law.

The evidence shows that the United States is being ruled over by a tribunal of murderers which has Hitler-like asserted to legalize mass murder, and maintains the killings year after year by willfully refusing to allow counsel to represent the victims being killed and defend the victims right to life under the U.S. Constitution. But even the Supreme Court is not above the law of murder, and many states still punish mass murder with the death penalty.

THE VICTIMS BEING KILLED BY ROE v WADE ARE CONSTITUTIONALLY ENTITLED TO BE ESPECIALLY REPRESENTED BY RETAINED COUNSEL TO DEFEND THEIR RIGHT TO LIFE UNDER THE CONSTITUTION.

The victims being killed have a constitutional right to be especially represented by retained(no cost to taxpayers) counsel to defend their right to life under the U.S. Constitution. [2]

Alan Ernest
Counsel

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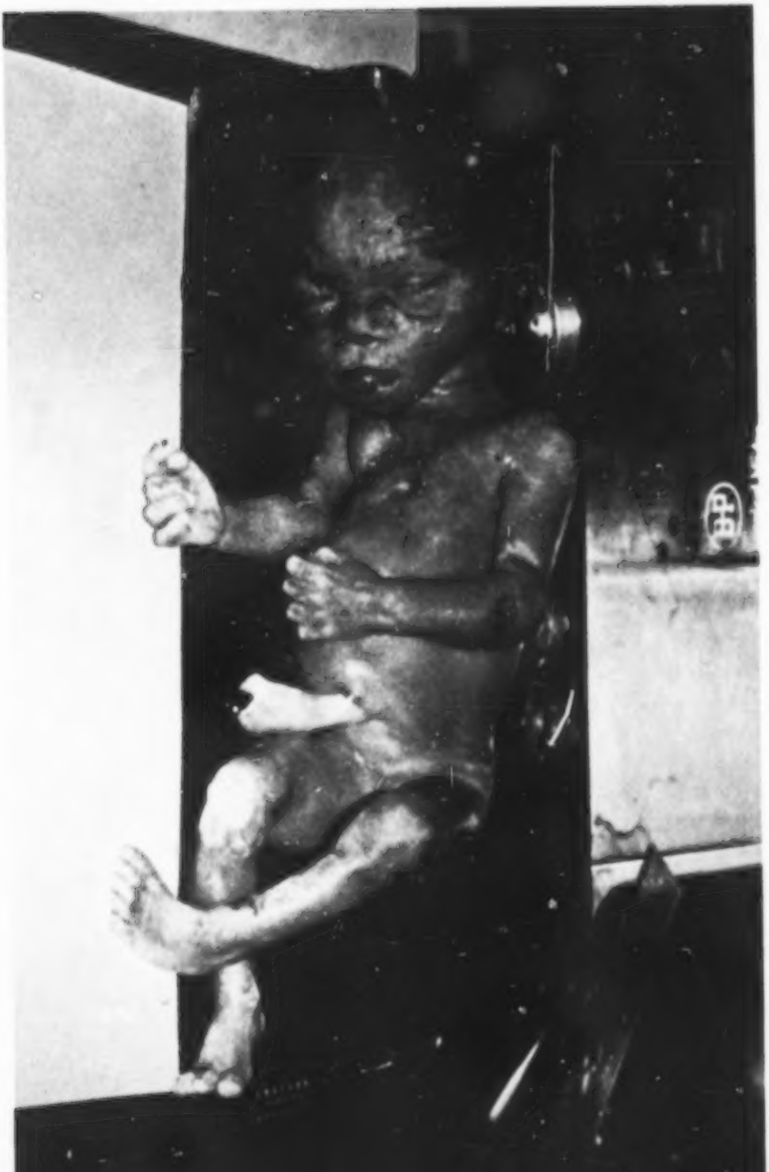
[2] Goldberg v Kelly, 397 U.S. 254, 268-270(1970). In Re Gault, 387 U.S. 1(1967); Morrissey v Brewer, 408 U.S. 471 (1972); Gagnon v Scarpelli, 411 U.S. 778(1973); Viteck v Jones, 63 L Ed 2d 552(1980); Gideon v Wainwright, 372 U.S. 335 (1963); United States v Altstoetter(The Justice Case), 3 Trials of War Criminals Before the Nuernberg Military Tribunals 1046 (1951).

The right to retained counsel under these circumstances is certain and indisputable. It can not be pretended that it is any longer the government of the United States, or any government of Constitution and laws, wherein judges assert to legalize mass murder, and then maintain the killings year after year by willfully refusing to allow counsel to represent the victims being killed and defend their right to life under the Constitution.

The amicus curiae brief filed herein by the Legal Defense Fund For Unborn Children is incorporated by reference in its entirety.



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The photograph, supra A-1, shows a second stage abortion by prostaglandin. Such abortions not uncommonly result in the child being born alive.[1/] This Court could be prosecuted for murder for such a killing. There have been many thousands of such killings under Roe v Wade. And witnesses live to tell.

And if the child were killed in the womb and born dead, then this Court could be prosecuted for criminal extermination in violation of the Fifth and Fourteenth Amendments and 18 U.S.C. 242.[2/]

As the Court studies the face of this victim of Roe v Wade, let it contemplate that a government of laws shall be restored, and the law shall call the killers to account.

[1/] Floyd v Anders, 440 F. Supp. 535,538(1977). The common second stage abortion techniques-hysterotomy, prostaglandin, and even salt poisoning-can result in the child being born alive. Jefferies & Edmonds, Abortion: The Dreaded Complication, The Philadelphia Inquirer, August 2, 1981.

[2/] The amicus curiae brief by the Legal Defense Fund For Unborn Children shows that the unborn are persons whose lives are protected by the Fifth and Fourteenth Amendments of the U.S. Constitution.Thus their lives are also protected by 18 U.S.C. 242.

Amicus Brief

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81-1255
81-1623

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IN THE

Supreme Court of the United States

OCTOBER TERM, 1981

PLANNED PARENTHOOD ASSOCIATION OF KANSAS CITY,
MISSOURI, INC., *et al.*
Petitioners,

v.

JOHN ASHCROFT, Attorney General of the
State of Missouri, *et ano.*
Respondents.

JOHN ASHCROFT, Attorney General of the
State of Missouri, *et ano.*
Petitioners,

v.

PLANNED PARENTHOOD ASSOCIATION OF KANSAS CITY,
MISSOURI, INC., *et al.*
Respondents.

ON A WRIT OF CERTIORARI TO THE UNITED STATES COURT
OF APPEALS FOR THE EIGHTH CIRCUIT

BRIEF *AMICUS CURIAE* OF THE NATIONAL ABORTION FEDERATION

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INTEREST OF AMICUS

This brief is filed on behalf of the National Abortion Federation (hereinafter NAF), a not-for-profit professional organization dedicated to preserving the right of all women to choose a safe legal abortion.[1] NAF does not promote the choice of abortion; rather it seeks to ensure that the means of effectuating that choice are both safe and accessible.

Founded in 1977 to provide a national professional forum for abortion service providers, NAF now has more than 230 abortion clinic members, including the institutional plaintiffs in this case, Planned

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[1] Counsel for the parties to this appeal have given their consent to the filing of this brief. Their letters of consent are filed with this Court.

Parenthood and Reproductive Health Services. NAF members also include physicians who provide abortion services in their offices as well as other organizations and individuals committed to the preservation and provision of safe legal abortions. NAF seeks to unite abortion service providers into a professional community dedicated to patient care of high quality.

NAF provides a panoply of programs to assist its members and all providers in meeting these goals. NAF has promulgated exhaustive standards, formulated by special committees of practicioners and experts, on the medical, nursing, counseling, administrative and ethical aspects of abortion services. NAF standards are designed and implemented to promote the health, safety and well-being of patients. They are reviewed regularly and updated to reflect the most advanced knowledge in the field. NAF's current standards are set forth in full as an appendix hereto. Whenever possible, NAF works closely with health departments and legislative bodies in order to promote awareness of and conformity with these standards for quality care.

NAF periodically assesses the need and trends in the profession and provides several forums for the presentation of new information based on technological advancement, research and experience. In addition to its annual meeting, NAF offers post-graduate risk management-quality assurance seminars, accredited by the American Medical Association for continuing education credits, which concern the prevention and management of complications of abortion. NAF also sponsors regional workshops in the areas of nursing, counseling, public affairs, and management.

NAF undertakes specific research and publishes reports as part of its public education program. A special NAF task force recently published a report entitled Minors and Abortions, a copy of which has been lodged with the court.

NAF has established the only national toll-free Hotline offering consumers information on a wide variety of subjects relating to abortions and reproductive health. The Hotline offers consumers general information about abortions, guidelines on how to choose an abortion facility, a list of NAF members in a particular area, and referrals to other organizations. NAF encourages feedback from Hotline consumers, and promptly investigates complaints about abortion providers. More than 10,000 women and men -- teenagers, parents, husbands, social workers, teachers, ministers and even judges -- have used the Hotline service. NAF also offers consumers a printed guide to choosing an abortion facility, an information brochure in English and Spanish about abortion, and a condensed version of the NAF standards.

NAF has recently instituted a Public Action Program in response to the threats to legal abortion. The program is designed to educate the professional community of abortion providers and, more important, the thousands of women and men who daily visit NAF clinics throughout the country and who are affected by the availability of abortion services in the most personal way.

NAF members provide approximately half of all the abortions in the United States. NAF constantly strives to assure that its members and the entire medical community have the tools and information to provide the best possible care. NAF opposes governmental attempts to interfere with and hamper the provision of quality care to abortion patients.

SUMMARY OF ARGUMENT

Missouri has once again placed unconstitutional roadblocks in the path of a woman seeking to effectuate her fundamental constitutional right to choose abortion. The Missouri statutes before this Court are not narrowly drawn to meet compelling state interests and thus cannot withstand the rigorous scrutiny applicable to laws inhibiting access to abortion.

To the extent that the statutory provisions directly interfere with women's access to abortion services, they impose a burden on the right to choose. To the extent that that burden is not narrowly tailored to meet a compelling state interest, it is undue and unconstitutional.

Missouri's restriction of second trimester abortion procedures to hospitals serves no compelling state interest in view of the technological advances in the provision of abortion services since Roe v. Wade, 410 U.S. 113 (1973),was decided. Becuase Dilatation and Evacuation procedures in the second trimester are as safe on an outpatient basis as childbirth, the state's interest in maternal health does not even become compelling until the end of the second trimester of pregnancy.

Even if the state had a compelling interest in maternal helath throughout the second trimester of pregnancy, the Missouri restriction fails as a regulation reasonably related to maternal health. Rather than promote women's health, the Missouri provision affirmatively harms women because it has the effect, no doubt consistent with its purpose, of denying second trimester abortions to women altogether. Only one hospital in Missouri provides second trimester abortion services. Thus the law requring that such procedures be performed in hospitals renders them unavailable.

ARGUMENT

POINT I

LEGISLATION THAT INTERFERES WITH THE EFFECTUATION OF THE FUNDAMENTAL RIGHT TO CHOOSE ABORTION CANNOT WITHSTAND RIGOROUS JUDICAL SCRUTINY UNLESS NARROWLY TAILORED TO MEET A COMPELLING STATE INTEREST.

This Court has long recognized that the Constitution guarantees a fundamental right of privacy in matters of reproductive choice. *Griswold v. Connecticut*, 381 U.S. 479 (1965); *Cf*. *Skinner v. Oklahoma*, 316 U.S. 535 (1942) (the right to procreate is a fundamental constitutional right).

In Roe v. Wade, 410 U.S. 113 (1973), this Court established that the "right of privacy...is broad enough to encompass a woman's decision whether or not to terminate her pregnancy." Id. at 153. Because the right of privacy guarantees independence in making certain fundamental decisions about whether or not to bear a child, state regulations interfering with the effectuation of these decisions "may be justified only by a 'compelling state interest'...and...must be narrowly drawn to express only" that interest. Id. at 155. Laws that limit access "to the means of effectuating" decisions in matters of childbearing receive the same rigorous scrutiny as laws that prohibit choice altogether, since "access is essential to exercise of the constitutionally protected right." Carey v. Population Services International, 431 U.S. 678, 688 (1977).

This Court has consistently applied the strict test enunciated in Roe v. Wade to state regulations that interfere with the right to choose abortion. Doe v. Bolton, 410 U.S. 179 (1973); Planned Parenthood of Central Missouri v. Danforth, 428 U.S. 52 (1976).[2] See also Bigelow v. Virginia, 421 U.S. 809 (1975).

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[2] Danforth sustained a requirement for a written informed consent and certain reporting requirements because they

[footnote continued]

The provisions of the Missouri statute presented for review here all present direct obstacles to the exercise of the right of privacy. Thus, this Court's decisions in Maher v. Roe, 432 U.S. 464 (1977), and Harris v. McRae, 448 U.S. 297, 100 S.Ct. 2671 (1980), do not affect the rigorous scrutiny required here. In Maher, this Court upheld a Connecticut statute that withdrew state funding from elective

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2/ [foonote 2 continued]
did not present any obstacle to a woman's decision to have an abortion or her ability to effectuate it. Therefore, rigorous review was unnecessary. 428 U.S. at 66-68, 80-81. In doing so, this Court cautioned states against informed consent and reporting provisions that burden the abortion decision and its effectuation. Id.

abortions. Finding that women had no fundamental right to state funds for elective abortions, the Court subjected the restriction to only minimal review in the equal protection context. Id. However, Maher made crystal clear that minimal review is not applicable to this case.

> Our conclusion signals no retreat from Roe or the cases applying it. There is a basic difference between direct state interference with a protected activity and state encouragement of an alternative activity consonant with legislative policy. Constitutional concerns are greater when the State attempts to impose its will by force of law; the State's power to encourage

> actions deemed to be
> in the public interest
> is necessarily far
> broader.

432 U.S. at 475-76.

Harris v. McRae, in which this Court upheld the federal withdrawal of Medicaid funds for most abortions, reiterated the direct interference/ funding distinction. 100 S.Ct. at 2686-88. Maher and McRae are both grounded on the finding that governmental failure to fund abortion simply is not a state-created obstacle to the effectuation of the fundamental right to choose abortion. In both cases, the majority specifically distinguished funding restrictions from the kind of direct state interference at issue here.

Recognizing the "presence of rascals in the medical profession as in all others," this Court nonetheless has held that states may not enact laws that "limit" a "woman's right to receive medical care [including abortion services] in accordance with her licensed physician's best judgment...." Doe v. Bolton, 410 U.S. 179, 197 (1973).

This Court has consistently "underscored the importance of affording the physician adequate discretion in the exercise of...medical judgment." Colautti v. Franklin, 439 U.S. 379, 387 (1979), citing Doe v. Bolton. See also, United States v. Vuitch, 402 U.S. 62 (1971). Since 1973, the medical community in this country has developed a new and innovative clinical model for the provision of abortion services in accordance with the highest medical standards, which assures comprehensive patient care of the highest quality.

Legislation that has the purpose and effect of discouraging the abortion choice and, if the choice is nonetheless made, of making abortion services more expensive and less accessible, directly interferes with the ability of women to effectuate the right to choose abortion and inevitably has an adverse impact on their health and well-being.

The Constitution ensures that women's right to effectuate the abortion decision may not be eroded by state interference with the provision of quality abortion services. This Court has the power and the duty to invalidate state and federal statutes in conflict with the Constitution. Martin v. Hunter's Lessee, 14 U.S. (1 Wheat) 304 (1806), Marbury v. Madison, 5 U.S. (1 Cranch) 137 (1803), This Court must be especially vigilant when fundamental rights are threatened in a climate of political turmoil. Cooper v. Aaron, 358 U.S. 7, 18-19 (1958).

Mr. Justice Jackson, writing for the Court in West Virginia Board of Education v. Barnette, 319 U.S. 624 (1943), illuminates the vital necessity of protecting fundamental rights from erosion or extinction through the political process:

The very purpose of a Bill of Rights was to withdraw certain subjects from the viscissitudes of political controversy, to place them beyond the reach of majorities and officials and to establish them as legal principles to be applied by the courts. One's right to life, liberty, and property, to free speech, a free press, freedom of worship and assembly, and other fundamental rights may not be submitted to vote; they depend on the outcome of no elections.

Nor does our duty to apply the Bill of Rights to assertions of official authority depend upon our possession of marked competence in the field where the invasion of rights occurs. True, the task of translating the majestic generalities of the Bill of Rights, conceived as part of the pattern of liberal government in the eighteenth century, into concrete restraints on officials dealing with the problems of the twentieth century, is one to disturb self-confidence. These principles grew in soil which

> also produced a philosopy that the individual was the center of society, that his liberty was attainable through mere absence of governmental restraints, and that government should be entrusted with few controls and only the mildest supervision over men's affairs.
>
> * * *
>
> But we act in these matters not by authority of our competence but by force of our commissions. We cannot, because of modest estimates of our competence...withold the judgment that history authenticates as the function of this Court when liberty is infringed.

Id. at 638-40.

This Court must enforce the fundamental right of privacy, which includes the right of a woman to choose and obtain an abortion, by rigorous review of state statutes that interfere with that right.

> To enforce those rights today is not to choose weak government over strong government. It is only to adhere as a means of strength to individual freedom of mind in presference to officially disciplined uniformity for which history indicates a disappointing and disastrous end.

Id. at 637.

POINT II

MISSOURI'S SECOND TRIMESTER RESTRICTION UNCONSTITUTIONALLY INHIBITS THE RIGHT TO ABORTION AND FAILS TO PROTECT HEALTH.

Missouri's restriction of second trimester abortion procedures to hospitals not only directly interferes with effectuation of the abortion decision, it literally precludes the choice of abortion for many women because only one Missouri hospital offers the service. See Planned Parenthood v. Ashcroft, 664 F.2d 687, 689 (8th Cir. 1981).[3/] However, even if the restriction were not virtually choice-preclusive, it would not withstand constitutional challenge because it bears no reasonable relationship to the protection of women's health. Roe v. Wade, 410 U.S. at 163.

[3/] Because of this extraordinary impact of the second trimester restriction, Amicus specifically addresses only that section of the Missouri statute. Amicus supports however the position of plaintiffs that all the provisions of the Missouri statute before this court are unconstitutional.

In Roe this Court held that, because second trimester abortions were less safe than childbirth,

> ...the state's important and legitimate interest in the health of the mother [becomes] "compelling..., in light of present medical knowledge,..." at approximately the end of the first trimester.

419 U.S. at 163 (emphasis added). This Court predicated its determination that a state's interest in maternal health became compelling at the beginning of the second trimester on the evidence of the relative safety of abortion and childbirth then available. Roe accordingly held that states could regulate abortions in the second trimester, but only "to the extent that the regulation reasonably relates to

the preservation and protection of maternal health." Id.

Suggested examples of permissible state regulation, including restricting second trimester procedures to hospitals or specially licensed clinics, were obviously drawn, inter alia, from the position of the American Public Health Association ("APHA"), which, at that time, recommended a hospital setting for all second trimester abortions because of substantial risk to women's health from these procedures. 410 U.S. at 144-46, 163.

During the period since Roe was decided, technological advances in the provision of second trimester abortions, pioneered by NAF members, have resulted in the availability on an outpatient basis of Dilatation and Evacuation (D & E) abortions, which were virtually unknown in 1973. D & E procedures on an outpatient basis are as safe as childbirth, as demonstrated by the record in this case. The APHA has accordingly changed its own policy and now recommends outpatient second trimester services. (See Brief *Amicus Curiae* of the APHA . *See also*, briefs *amici curiae* of the Planned Parenthood Federation of America and the American College of Obstericians and Gynecologists which document the literature detailing the safety of outpatient D & E abortions and support the position urged here.)

The technological strides made since Roe make clear that the state's interest in maternal health does not become compelling and thus justify regulation until the end of the second trimester of pregnancy. See Margaret S. v. Edwards, 488 F. Supp. 181, 194-196 (E.D. La. 1980).[4/] Even were this Court to

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[4/] Gary-Northwest Indiana Women's Service, Inc. v. Orr, 451 U.S. 934 (1981) aff'd 496 F. Supp. 894 (N.D. Ind. 1980) does not affect the result urged here. In Gary-Northwest, this Court summarily affirmed the refusal of a three-judge court to vacate its earlier judgment and enjoin an Indiana statute restricting second trimester abortions to hospitals. That statute, in sharp contrast to this one, defined hospitals to include ambulatory outpatient surgical centers. Summary affirmances reject only the specific challenges presented in the jurisdictional statement. Mandel v. Bradley, 432 U.S. 173, 176 (1977), Fusari v. Steinberg, U.S. 379, 391-393
(footnote continued)

draw the line at an earlier point, Missouri's hospital restrictions do not promote maternal health in any event. Women's health is better served by the provision of outpatient D & E procedures. Indeed, in this case, where hospital restrictions virtually cut off services because Missouri hospitals don't provide them, the restriction

---

4/ (footnote 4 continued)
(1975) (Burger, C.J. Concurring). The only arguably substantive issue presented in Gary-Northwest, which presented several procedural questions irrelevant to this case, was "whether the lower court had abused its discretion in failing to issue a preliminary injunction." No. 80-1275, Jr. St. at i (emphasis added). Reversal of the granting or denial of a preliminary injunction requires "a strong showing" that the lower court ruling "was plainly the result of an improvident exercise of judicial discretion." Railway Express
(footnote continued)

> fails as a reasonable regulation for the protection of maternal health. It comes into focus, instead, as an unreasonable or arbitrary regulation designed to inhibit, and having the effect of inhibiting, the vast majority of abortions after the first 12 weeks.

Planned Parenthood of Central Missouri v. Danforth, 428 n.s.52, 79 (1976).

Thus, like the ban on the saline method struck down in Danforth,

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4/ (footnote 4 continued) Agency v. U.S., 7 L.Ed.2d 432, 434 (1962), quoting United Fuel and Gas co. v. Public Service Commission, 278 U.S. 322, 326 (1929). "In reviewing... interlocutory relief, this Court... intimate(s) no view as to the ultimate merits..." Brown v. Chote, 411 U.S. 452, 457 (1973). Thus, the summary affirmance in Gary-Northwest has no bearing on this case which has been fully litigated on the merits.

Missouri's latest attempt to inhibit second trimester abortions is also unconstitutional.

CONCLUSION

For the reasons stated above this Court should hold unconstitutional all of the Missouri statutory provisions restricting access to abortion services.

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Auguat 2, 1982

NATIONAL ABORTION FEDERATION

STANDARDS

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FOREWORD

While the National Abortion Federation is an organization specifically committed to questions of the provision of quality abortion services for women, it recognizes that education about abortion procedures and services should be the responsibility of all health agencies and professionals concerned with the care of women. Health professionals in every state should accept this educational responsibility. These agencies and individuals should assume a leadership role in making essential facts known to the public, other health professionals and non-professionals who have contact with individuals in need, and members of all branches of government who must make informed decisions about the role of abortion in our society. The facts are:

* Women should be as free as possible in their personal choice involving abortion and should not be coerced in any way.

* Individuals contemplating abortion should be encouraged to seek information and counseling from the best available source.

* Educational literature on abortion should be easily obtainable. Such literature should indicate the means by which individuals obtain information and services, describe the current legal status of abortion, discourage individuals from seeking a dangerous illegal abortion, emphasize the availability of contraception as a means of avoiding unwanted pregnancy, make

available information regarding Medicaid, other insurance coverage, and other sources of funds for those in need; and supply information on the availability of contraception and male or female sterilization.

* Both risks and costs are less when abortion is sought early in pregnancy.

* The symptoms of pregnancy should be widely known so that those wishing to terminate an unwanted pregnancy may seek assistance at the earliest stage of pregnancy. Since the risks of complications are lowest in early pregnancy, the early detection of pregnancy and determination of appropriate management should be encouraged.

* The diagnosis of pregnancy should be confirmed prior to abortion through the

performance of adequate physical examination and reliable laboratory tests for pregnancy.

* If travel to another community for an abortion is contemplated, patients should confirm the actual presence and stage of pregnancy before travel plans are made.

* Abortion should be legally performed by or under the supervision of licensed physicians who have been adequately trained to prevent, recognize, and treat the complications which may ensue.

* Adequate followup care, which includes the identification and knowledge of specific contacts for post-procedure medical services, is essential to the prevention and detection of post-abortion complications.

PREAMBLE

Abortion is a health service and should be provided to the public with the same attention to standards of safety, effectiveness, and regard for patient rights as other health services. Abortion services are an integral part of comprehensive family planning and maternal and child care.

The availability of safe abortion services to all who need them is essential to community health, personal freedom, and individual dignity. The National Abortion Federation is committed to the provision of these services under humane circumstances whenever and wherever they are offered.

In order to insure that these purposes are fulfilled, we believe that standards in abortion services should be followed in the areas of counseling, nursing, medical and surgical procedures, informed consent, followup care, ethics, administration, reporting and referral.

The rigorous maintenance of high standards of care does not preclude the development of new techniques and innovative methods of service delivery that achieve quality care.

Where a facility departs from a stated NAF standard, the facility is expected to provide full documentation of the alternative they have chosen and demonstrate its effectiveness in fulfilling the intent of the standard in question.

All underlined sections in this document are obligatory standards for NAF member facilities and must be current practice for membership in good standing.

All other sections are advisory and strongly recommended.

COUNSELING STANDARDS

Philosophy of Counseling

Decision counseling seeks no predetermined outcome, but encourages exploration of all possible alternatives, the final choice resting entirely with the woman. By establishing a relationship based on empathetic understanding and non-judgmental support, the counselor attempts to assist women as necessary with decision making, anxiety reduction, and informed consent. The woman's autonomy and control should be supported to the fullest. The counseling contract should be agreed upon by the woman and the counselor at the beginning and should clearly identify the counseling objectives. These should be distinguished from other issues and objectives such as the provision of information.

It should be assumed, unless evidence is otherwise presented, that the woman is mentally competent. Like other major life decisions, decisions around pregnancy may involve confusion, ambivalent feelings, and value conflicts which make counseling an important part of the service provided. However, it does not mean necessarily that the woman is sick or helpless. Counseling should be offered but not imposed, and it should not constitute a barrier to appropriate service. Counseling should always be consistent with the needs of the woman.

Objectives of Counseling

The following objectives must be fulfilled in response to the need of the individual woman and should be accomplished on an individual basis in privacy. The opportunity for individual counseling must be offered to every woman:

* to assist the pregnant woman, as needed, in exploring her feelings about her pregnancy, her circumstances, and her options;

* to assist the woman, as needed, in decision-making by helping her face the task of choosing, encouraging a careful examination of all options, providing accurate information, and supporting her right to choose for herself, free of all coercion so that she retains her sense of autonomy and control;

* to refer, when appropriate, for implementation of the woman's choice or for further counseling or additional medical services.

The following objectives must be

fulfilled with every woman who chooses abortion and may be accomplished either on an individual basis or in group sessions, providing that attendance at a group session is voluntary:

* to insure informed consent by establishing that the patient is mentally competent and appears to understand the nature and consequences of the procedure;
* to prepare the woman for surgery in a manner that facilitates her safety and comfort;
* to offer the woman an opportunity to understand her fertility, to assist her in reaching a decision about the method of contraception she will use, if any, and respecting her choice.

Qualifications of Counselors

The counselor should be an empathetic, responsive, caring person who understands how to discipline herself in order to be helpful to others.

She should be comfortable with her own sexuality and nonjudgmental in her attitude toward the sexuality of others.

She should understand how to help a woman make health care decisions and be able to distinguish those decisions from moral and medical judgments, which have no place in the counseling session.

She should understand and observe a professional code of ethics.

She should be receptive to supervision and to training in counseling skills and family planning practices.

Training and Supervision

Counselors must be provided initial training that covers at least the following topics in detail:

- sexual and reproductive health

* abortion technology

* contraceptive technology

* short-term counseling skills

* community resources and referrals

* informed consent

* agency policies and practices

NURSING CARE STANDARDS

Objectives

The objectives of abortion nursing services include:

* the use of the nursing process to assist each patient in reaching her highest level of emotional and physical well-being before, during, and after her abortion;

* the provision of each patient with basic knowledge about her health so that she may make informed choices regarding her own health care;

* the provision of a safe and health-promoting environment for each patient.

Qualifications of Nursing Staff

The nursing staff includes appropriately trained health workers including but not limited to each licensed professional, practical, or vocational nurse.

Each staff person providing nursing care must acknowledge and practice within her professional and/or prepratory limits.

Those responsible for nursing care must be skilled in inter- personal communication. These skills include interviewing, crisis intervention, support, and health education. They must exhibit skill in direct patient care, surgical nursing, sterile technique, and the documentation and reporting of these actions.

Each person responsible for nursing functions must understand the basics of reproductive physiology, have a knowledge of contraceptive technology, and have an understanding of the mode of action, adverse effects and contraindications of medications being dispensed. Each must understand the proper operation and routine maintenance of all medical equipment used. In particular, each must be familiar with the location and proper use of emergency medications and equipment. Knowledge of the emergency protocol and procedure as set forth by the medical director is essential.

Nursing care providers must be sensitive and empathetic to the unique needs of each individual patient and must be committed to maintaining a pro-choice, non-judgmental attitude. They must understand the flow of patients within the facility in order to assure the routine provision of appropriate medical care. They must participate as active members of the health care team.

Those staff members functioning in an expanded nursing role must operate within the limits of written, current and signed medical orders and/or within written protocols and procedures. They must demonstrate an understanding of the implications of their clinical findings, have direct access to medical consultation, and be supervised by a physician licensed in the state in which the practice occurs.

Supervision of Nursing Care

Nursing care must be supervised by a registered nurse or physician. The nursing care supervisor must be capable of directing response in emergency situations, and must participate actively as a member of the health care team. A nurse, physician, or appropriately competent and licensed medical person must be present in the facility while abortions are being performed and during the time the patients are recovering.

Training of Nursing Staff

Nursing care providers should be provided with a training and orientation period appropriate to the needs and level of preparation of each individual.

The orientation should include information concerning:

* preoperative, operative, and postoperative abortion nursing procedures;

* reproductive anatomy and physiology;

* sexual health;

* current contraceptive technology;

* emergency procedures;

* sterile technique;

* documentation and charting;

* agency policies;

* nursing's role as part of the health care team;

* stress management.

MEDICAL CARE

Quality abortion services should be readily available to all patients who desire these services. Abortion should be an integral part of medical education and of residency training in obstetrics and gynecology and in family practice. Important factors related to the incidence of complications with abortion are the skill and experience of the operating practitioner and the presence of a well-educated supporting staff.

Customary surgical principles dictate the following standards for an abortion faciity:

Pre-operative Care

* An adequate preoperative history and physical examination must be conducted, to include:

an accurate determination of the

duration of gestation;

the identification of any pre-existing conditions or complications; and

the detection of any factors which could influence the choice of procedure, anesthesia, or the pre- and post-operative management.

* Urine testing for pregnancy is essential except when a positive diagnosis of pregnancy has been established by other means such as diagnostic ultrasound. Laboratory procedures to determine hematocrit and Rh factor in every case are mandatory. The desirability of other laboratory procedures will depend upon the population served. These may include sickle cell testing, endocervical and anal culture for gonorrhea, urinalysis, serologic test for syphilis, and when

indicated, cytologic screening for cancer.

Operative Care

* Abortions must be performed only by licensed physicians or by non-physicians who are permitted to do so by applicable law who perform abortions under the supervision of a licensed physician. All personnel performing abortions must have received prior special training in the performance of abortions, and in the prevention, recognition, and treatment of the complications which may ensue.

* All practitioners must work under a Medical Director who is a licensed physician. It is mandatory that the Medical Director or facility have a working arrangement with a physician who has admitting privileges at a local

hospital in order to insure the necessary back- up for medical complications.

* General anesthesia must be given by an anesthesiologist or nurse anesthetist with a physician trained in the treatment of anesthesia complications on the premises.

* Every reasonable effort must be made to evacuate the uterus completely. All tissue must be examined grossly at the time of the abortion procedure by a physician or trained assistant and the results recorded in the chart. In the absence of visible fetal parts or placenta upon gross examination, obtained tissue may be examined under a low power microscope for the detection of villi. If this examination is inconclusive, the tissue should be sent to the nearest suitable pathology laboratory for

microscopic examination. The laboratory discovery of tissue other than that usually associated with uncomplicated intrauterine pregnancy must be reported within 48 hours to the abortion service of operating practitioner for appropriate followup (e.g. trophoblastic disease; suspected ectopic pregnancy). There must be an appropriate mechanism for contacting the patient and informing her of the significance of the report.

Postoperative Care

* The recovery area must be supervised by a licensed nurse or physician who is immediately available to the recovery area. The staff/patient ratio in the recovery area should be appropriate and adequate with regard to the anesthesia used. A physician must be immediately available to the facility as

long as there are patients in the recovery area.

* Prior to discharge, postoperative care should be directed toward confirming that the patient is at minimal risk of serious complications. Periodically, the patient's pulse rate, blood pressure, and external bleeding must be examined for evidence of intra-abdominal bleeding or injury. These observations should be made during the postoperative period, the length of which is partly dependent upon the operative procedure employed. If systemic drugs are used for analgesia/anesthesia, the patient must be fully reactive before discharge.

* The facility must provide continued contact for an availability of postoperative care on a 24-hour basis.

Drugs and Medications

* Drugs, parenteral fluids, and electrolyte solutions must be available in sufficient supply. Physiologic solutions (i.e. normal saline, Ringer's lactate) should be available for use during intravenous infusion of oxytocin. Rh-immune globulin must be explained and administered to Rh-negative patients. Fully informed consent must be obtained from those refusing. Narcotic antagonists must be available when parenteral narcotics are used.

Equipment and Physical Plant

* The facility must have the necessary equipment and gases (including oxygen) for artificial ventilation and for cardiac and pulmonary resuscitation.

* The operating table or conventional gynecologic examining table with accessories must be located in a

room of adequate dimensions, illumination, and ventillation.

* Surgical instruments must be sufficient in number to permit individual sterilization of the instruments used for each procedure and adequate to perform conventional cervical dilatation and curettage. Equipment for vacuum aspiration must be electrically safe and designed to prevent reverse pump action.

* The facility must have the capability to transfer a patient immediately to a hospital operating room for emergency care.

Medical Personnel

* It is the responsibility of the facility to provide for periodic, systematic, and confidential peer review of all practitioners performing abortions and other procedures (e.g. IUD

insertion). This review will include a minimum of:

* observation of operative technique;

* review of complications;

* review of a reasonable random sample of each practitioner's charts;

* review of each practitioner's interaction with patients.

Second Trimester Procedures

All provisions stated above will apply to second trimester procedures, and the following additional standards will be observed:

* Counseling services specifically oriented to the needs of second trimester patients must be available.

* The use of diagnostic ultrasound prior to termination of second trimester pregnancy is highly advisable for

determination of fetal age.

* If a dilatation and evacuation (D&E) procedure is performed under general anesthesia, it is advisable for it to be performed on the premises of a full-service hospital.

* All second trimester procedures performed on an outpatient basis must have immediate access to a full-service hospital within 15-20 minutes door-to-door.

* The procedure must be performed by a licensed physician who has been specifically trained in the performance of this procedure.

* A patient having saline amnioinfusion abortion must be supervised carefully during saline infusion and during oxytocin stimulation to prevent

electrolyte imbalance.

* Fetal expulsion must be planned for occurrence in a medically safe environment such as a hospital or specially equipped clinic facility.

* In amnioinfusion abortion, the patient must be evaluated within two hours after fetal expulsion to determine whether expulsion of the placenta has occurred.

* Nursing services specifically oriented to the needs of second trimester patients must be available for their care.

Emergency Protocol

* Each facility must have a written protocol for emergency evacuation of patients and should conduct regular drills.

* In the evacuation of a patient, medical personnel from the facility should accompany the patient.

* If an ambulance service is not immediately available, the faciity must maintain emergency transportation.

* The Medical Director is responsible for assuring that the patient is properly admitted to the hospital and has competent care from that point.

* All medical staff members must be proficient in cardiopulmonary resuscitation and it is highly advisable that other staff members be proficient in CPR.

* Drugs should be available for the following complications:

cardiac arrest
seizure
asthmatic attack
allergic reaction
narcotic toxicity

hypovolemic shock

* Emergency medications should include:

Narcan R

epinephrine

phenobarbitol injectable USP

Benadryl R

aminophilline

* The following emergency equipment must be available and checked for proper function at regular intervals:

plastic airway

resuscitation bag

cardiac arrest board

defibrillator if general anesthesia is administered

laryngoscope

endotracheal tube

large bore IV catheter needles

IV fluids, tubing and support

oxygen

ETHICAL STANDARDS

Determination of Gestational Age

Because the safety of abortion is partly dependent upon the stage of gestation at which it is performed, abortion providers have an obligation to determine gestational age as accurately as possible prior to the choice of procedure. This is particularly important in the later stages of the midtrimester (after approximately 19 weeks LMP).

Policy Statement on Delay of Abortion

The National Abortion Federation recommends that whenever practical, an abortion should be performed within one week of the request to terminate the pregnancy. This includes women who are unable to pay at the time they seek an abortion. It is especially critical that women not be delayed in having abortions during the 12th through 16th menstrual weeks of gestation.

Should an abortion facility not be able to provide a dilatation and evacuation (D&E) procedure during this interval, it is the facility's obligation to refer women immediately to facilities where such procedures are performed in accordance with NAF standards. Should referral not be possible, women must be informed of the increased risk in delaying until the 17th menstrual week of gestation.

It is the responsibility of abortion facilities, medical schools, and teaching hospitals to train physicians to perform the D&E procedure used during this interval.

Provision for Financial Assistance in

Cases of Complications

An abortion facility should have prior adequate financial arrangements, detailed in a written protocol, to be able to compensate patients who have suffered damages as a result of malpractice. This can include insurance, reserves, or other responsible options.

Public Assistance Funds

In order to fulfill Article II of the NAF Bylaws, members should pursue all possible efforts to be able to receive public assistance funds for both abortion procedures and/or the ancillary services related to abortion and family planning. This includes filing the necessary forms and compliance with state and local regulations for reimbursement.

Fee Schedules

All member facilities must

prominently display patient fees at reception and cashier offices, indicating services included.

ADMINISTRATIVE PROCEDURES

Personnel Policies and Procedures

NAF member facilities must provide vacation and sick leave benefits for full-time staff members. NAF recommends an annual vacation leave of two weeks (10 days) and sick leave of one day per month (12 days annually). Health insurance coverage is also recommended for employees of NAF member facilities. A written job description including an outline of duties and qualifications should be available for each position. The job descriptions should be updated as duties change.

Performance appraisals should be in writing with the supervisors' and employees' signatures. Performance appraisals should be kept in the employee personnel folder along with other information pertaining to that employee. The employee has the right to review his/her personnel file upon request. The employee also has the right to an interview by his/her supervisor when requested.

The member facility should provide malpractice coverage to its employees while performing their jobs. Each facility must support Affirmative Action Practices in staffing and advertising positions.

There must be a written and posted protocol for life-threatening medical emergencies. In addition, there must be written descriptions of procedures and policies in each area of care including:

nursing
counseling

abortion procedures

laboratory services.

It is recommended that clinic hours be set considering the needs of the patients as well as the staff.

Clinic Security

Written guidelines must be available for all staff relating to non-medical emergency procedures. These should be posted in a place appropriate for inspection by staff members.

It is recommended that a smoke and burglar alarm system be installed in each facility.

Patient Fees and Records

Each facility should be morally obliged to have policies to accomodate low-income women. Specific financial arrangements should be made available to a minimum of 10% of the patient load.

There must be a contractual agreement between the woman and the facility outlining the payment plan and the collection policies. Collection policies must be in compliance with federal guidelines. The patient's record must not be released without the consent (preferably in writing) of the patient.

Confidentiality

Every woman has the right to expect her privacy will be respected and confidentiality of her records protected. Since most states do not have legislation protecting the confidentiality of medical records, care must be taken when making notation on her record (particularly counseling notes). In addition, if a member of the facility receives a subpoena for a woman's records, action must be taken to prohibit the release of the records without the woman's consent.

Additional suggestions to protect confidentiality:

* Keep all doors locked in accordance with fire code except the door where the patients enter.

* Shred all waste paper that may have a patient's name or information before discarding.

* Lock all information with patient's names, including appointment books and daily logs each night.

* Keep any and all paper work with identifying names and numbers in desks - not unattended in full view of others in the clinic.

* Never disclose information about a patient that may be in the facility to a telephone caller; rather state that if that person is in the facility, she can

call the person back, and have them leave a number.

Minors

Minors should be served in the same manner as other women, keeping in mind possible restrictions upon hospital admissions without parental consent. If hospitals will not admit without parental consent, minors should be made aware that, in case of emergency, it may not be possible to maintain confidentiality.

Administrative Supervision

While direct professional supervision of physicians, nurses, and counselors is the responsibility of the senior professional in each area, the chief administrative officer responsible for the general supervision of clinic functions must assure that personnel policies and procedures are formulated, distributed, and observed in an equitable manner.

In a professional organization such as an abortion service, this includes the arrangements for continuing training in the form of individual supervision, in-service education programs, and continuing education opportunities for all professional and paraprofessional staff members.

Individual agencies are responsible for knowledge of current local nurse practice acts. Agencies may not require nurses to practice outside the legal limits of local nurse practice acts.

Agencies are also responsible for knowledge of the current state of licensure and professional liability insurance for physicians engaged in medical practice within the facility or those acting in its name.

REPORTING STANDARDS

The maintenance of complete and accurate records is important for quality patient care and meaningful review of services. Reporting of legally induced abortions to public agencies where required and to non-public agencies is essential for providing and improving maternal health and family planning services. Confidentiality of individual patient identity is essential and must be safeguarded in abortion reporting.

In order to provide a uniform basis for evaluation of abortion services, the National Abortion Federation requests each participating institution to provide the following data on a quarterly basis:

* the number of abortions performed;
* length of gestation;
* the percentage of patient followup

contact made within six weeks of the abortion;

- the number of deaths;
- the number of patients receiving one or more blood transfusion;
- perforation, known or suspected;
- the number of patients experiencing pelvic infection requiring hospitalization of at least 72 hours within two weeks of the abortion;
- the number of repeat abortion procedures because of retention of tissue within one month of the original procedure.

Data from individual institutions will be treated confidentially. The aggregate data will be analyzed and made available to participants. This data collection is distinguished from abortion reporting required by state or local health departments.

REFERRAL STANDARDS

NAF member institutions which provide referral for abortion services are required to observe the following standards:

* Referrals must be limited to qualified physicians and services that maintain high standards. Those providing referral services must investigate and evaluate periodically the facilities to which they refer. Referral must be made to abortion facilities which have received an on-site inspection by either the referring agency or some other agency whose report is available.

* Whenever facilities are available, the woman should be offered an examination to establish the diagnosis and stage of pregnancy prior to referral.

* The state of health of the woman,

as well as the length of gestation, should be factors in determining the recommended choice(s) of the physician or service for referral.

* The facility providing the abortion service has a responsibility to report back, with the woman's consent, to the referring agency.

* No provider shall own or participate in a captive referral agency either proprietary or non-profit, that is not clearly identified to the consumer as affiliated with the provider service in question.

* Women must pay the fee for services to the agency rendering the service. If a referral agency offers counseling or aftercare services or charges a fee for referral, they must do so directly. Abortion facilities may not use referral

agencies to collect fees for abortion and related services. This does not include situations where contracts for third party payment for public-assistance patients are required for reimbursement.

Amicus Brief

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Nos. 81-185, 81-746 and 81-1172, 81-1255 and 81-1623

IN THE

Supreme Court of the United States

OCTOBER TERM, 1982

◆

CHRIS SIMOPOULOS, M.D., FACOG,
Defendant-Appellant,
—v.—
COMMONWEALTH OF VIRGINIA,
State-Appellee.

CITY OF AKRON, et al.,
Defendants-Petitioners,
—v.—
AKRON CENTER FOR REPRODUCTIVE HEALTH, INC., et al.,
Plaintiffs-Respondents.

(Caption continued on inside front cover)

ON APPEAL FROM THE SUPREME COURT OF VIRGINIA AND ON CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SIXTH CIRCUIT AND THE UNITED STATES COURT OF APPEALS FOR THE EIGHTH CIRCUIT

MOTION FOR LEAVE TO FILE BRIEF AMICI CURIAE AND BRIEF AMICI CURIAE ON BEHALF OF NATIONAL ORGANIZATION FOR WOMEN; NATIONAL ABORTION RIGHTS ACTION LEAGUE; NORTHWEST WOMEN'S LAW CENTER; WOMEN AND HEALTH ROUNDTABLE AND WOMEN'S LAW PROJECT

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AKRON CENTER FOR REPRODUCTIVE HEALTH, INC., et al.,
Plaintiffs-Petitioners,
—v.—
CITY OF AKRON, et al.,
Defendants-Respondents.

PLANNED PARENTHOOD ASSOCIATION OF KANSAS CITY,
MISSOURI, INC., et al.,
Plaintiffs-Petitioners,
—v.—
JOHN L. ASHCROFT, ATTORNEY GENERAL OF THE STATE
OF MISSOURI, et al.,
Defendants-Respondents.

JOHN L. ASHCROFT, ATTORNEY GENERAL OF THE STATE
OF MISSOURI, et al.,
Defendants-Petitioners,
—v.—
PLANNED PARENTHOOD ASSOCIATION OF KANSAS CITY,
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Plaintiffs-Respondents.

In the
SUPREME COURT OF THE UNITED STATES
October Term, 1982

No. 81-185

Chris Simopoulos, M.D., FACOG,
Appellant,
v.
Commonwealth of Virginia,
Appellee.

Nos. 81-746 and 81-1172
City of Akron, et al.,
Defendants-Petitioners,
v.
Akron Center for Reproductive
Health, Inc., et. al.,
Plaintiffs-Respondents.

Akron Center for Reproductive
Health, Inc., et al.,
Plaintiffs-Petitioners,
v.
City of Akron, et al.,
Defendants-Respondents.

Nos. 81-1225 and 81-1623

Planned Parenthood Association of
Kansas City, Missouri, Inc., et al.,
Plaintiffs-Petitioners,
v.
John L. Ashcroft, Attorney General
of the State of Missouri, et al.,
Defendants-Respondents.

John L. Ashcroft, Attorney General
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Kansas City, Missouri, Inc., et al.,
Plaintiffs-Respondents.

ON APPEAL FROM THE SUPREME COURT OF VIRGINIA AND ON CERTIORARI TO THE UNITED STATES COURTS OF APPEALS FOR THE SIXTH AND EIGHTH CIRCUITS

MOTION FOR LEAVE TO FILE BRIEF AMICI CURIAE OF NATIONAL ORGANIZATION FOR WOMEN, NATIONAL ABORTION RIGHTS ACTION LEAGUE, NORTHWEST WOMEN'S LAW CENTER, WOMEN AND HEALTH ROUNDTABLE, AND WOMEN'S LAW PROJECT

The National Organization for Women, National Abortion Rights Action League, Northwest Women's Law Center, Women and Health Roundtable and Women's Law Project respectfully move, pursuant to Rule 36.3 of this Court's Rules, for leave to file the attached brief *amici curiae*. Counsel for Appellant Chris Simopoulos, Petitioner City of Akron, Respondent Akron Center for Reproductive Health, Petitioner Ashcroft and Respondent Planned Parenthood Association of Kansas City have consented to the filing of this brief and their letters of consent have been filed with the Clerk. The Commonwealth of Virginia has refused consent.

The NATIONAL ORGANIZATION FOR WOMEN is a national membership organization of 170,000 women and men in over 750 chapters throughout the country. NOW has as one of its priorities, the preservation of the right to reproductive freedom, including abortion. NOW believes that every woman has a fundamental constitutional right to decide whether to terminate her pregnancy by abortion. NOW submits that the restrictions challenged herein impermissibly impinge upon this constitutionally protected right.

The NATIONAL ABORTION RIGHTS ACTION LEAGUE is dedicated to keeping abortion legal, safe and available. It has more than 150,000 national members plus affiliates with their own membership drawn from the pro-choice majority throughout the country.

The NORTHWEST WOMEN'S LAW CENTER is a non-profit public interest law organization dedicated to securing equal rights for women through law. Located in Seattle, the Law Center conducts community and continuing legal education programs throughout the Northwest on women's legal rights; offers information and referral, and advice and counseling services; and provides legal representation or assistance in selected cases that will impart the laws and legal rights of large numbers of women.

The WOMEN AND HEALTH ROUNDTABLE, a project of the Federation of Organizations for Professional Women, is an association of organizations and individuals concerned with women's health issues and policy. Through a series of publications and forums during its five year history, the Roundtable has monitored public health policy and analyzed its implications for women. The Roundtable is concerned that policies such as those before this Court, would infringe on a woman's constitutionally protected right to choose to terminate her pregnancy.

The WOMEN's LAW PROJECT is a non-profit public interest law firm working since 1973 to challenge sex discrimination in the law and in legal and social institutions.

Amici are womens' rights organizations whose constituencies and interests are seriously affected by the decisions in these cases. At issue is the constitutionality of governmentally created obstacles to the exercise of a woman's constitutionally protected right to decide whether to terminate a pregnancy. *Amici* request leave to file this brief because of the extraordinary importance of these cases to the lives of women and children. *Amici* believe that their brief will elaborate for the Court the grave impact on individuals of the government restrictions challenged herein.

Respectfully submitted,

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In the
SUPREME COURT OF THE UNITED STATES
October Term, 1982

No. 81-185

Chris Simopoulos, M.D., FACOG,
Appellant,
v.
Commonwealth of Virginia,
Appellee.

Nos. 81-746 and 81-1172
City of Akron, et al.,
Defendants-Petitioners,
v.
Akron Center for Reproductive
Health, Inc., et. al.,
Plaintiffs-Respondents.

Akron Center for Reproductive
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Nos. 81-1225 and 81-1623

Planned Parenthood Association of
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ON APPEAL FROM THE SUPREME COURT OF
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UNITED STATES COURTS OF APPEALS FOR
THE SIXTH AND EIGHTH CIRCUITS

BRIEF AMICI CURIAE OF THE
NATIONAL ORGANIZATION FOR
WOMEN, NATIONAL ABORTION
RIGHTS ACTION LEAGUE,
NORTHWEST WOMEN'S LAW
CENTER, WOMEN AND HEALTH
ROUNDTABLE AND WOMEN'S
LAW PROJECT

INTEREST OF AMICI

The interest of amici appears in the foregoing motion.

INTRODUCTORY STATEMENT AND SUMMARY

These three cases involve attempts by state and local governments to restrict the opportunity of a woman to exercise her constitutionally protected decision to terminate her pregnancy. In Simopoulos v. Commonwealth of Virginia, No. 81-

185, the constitutionality of a Virginia statute that requires, inter alia, that all post-first trimester abortions be performed in hospitals is being challenged by a physician convicted of violating this law. He is appealing from the Virginia Supreme Court's affirmance of his conviction. 221 Va. 1059; 277 S.E.2d 194 (1981).[1] A Missouri statute similarly requiring that all abortions after the first trimester of a pregnancy be performed in hospitals is at issue in Ashcroft v. Planned Parenthood Association of Kansas City, Nos. 81-1225 and

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[1] Other issues raised by Dr. Simopoulos on appeal include whether the burden of proof imposed on him was improper and whether the prosecution failed to produce evidence necessary for conviction. These issues of due process and fairness in criminal proceedings, although important, are outside the specific interests of amici and are not addressed herein.

81-1623. The Eighth Circuit upheld the constitutionality of this provision, 655 F.2d 848 (8th Cir. 1981).[2]

City of Akron v. Akron Center for Reproductive Health, Nos. 81-746 and 81-1172, involves a challenge to the constitutionality of an Akron, Ohio ordinance that imposes an in-hospital requirement similar to those in the Virginia and Missouri laws. In addition, the Akron ordinance requires that a woman seeking an abortion be counseled by the attending physician; that she be told specified information before she consents to an abortion; and that she wait 24 hours after she consents before obtaining an abortion. The Sixth Circuit upheld the in-hospital requirement, but declared the counseling, consent and waiting period provisions unconstitutional, 651 F.2d 1198 (6th Cir. 1981).[3]

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[2] Also presented for review are requirements that: minors obtain judicial authorization or parental consent for an abortion; a pathology report be submitted for every abortion; two physicians be present at all second trimester abortions. All but the first of these provisions were struck down by the Eighth Circuit. Although amici believe that all three of these provisions are invalid, they will not address them further herein.

These statutory schemes all have the effect of burdening the procreative decisions of women. Amici believe that individuals have the constitutionally protected right to make such decisions free from government interference. In this brief, amici demonstrate the serious restrictive impact of certain of the legislative enactments at issue in these cases. Although some of these provisions were upheld and some struck down by the lower courts, amici argue that none of these restrictions can survive the strict judicial scrutiny mandated by this Court's precedents, and all should be invalidated.

---

[3] Other provisions of the Akron ordinance presented for review in this Court are requirements that all minors seeking abortions notify at least one parent and, if the minor is under 15 years of age, obtain the consent of at least one parent; and that the fetus be disposed of in a "humane" manner. These provisions were struck down by the Sixth Circuit. Amici believe that the Sixth Circuit's decision should be affirmed, but will not address these issues further herein.

ARGUMENT

I.

THE CHALLENGED REGULATIONS SERIOUSLY RESTRICT — AND IN SOME INSTANCES EFFECTIVELY ELIMINATE — THE FUNDAMENTAL RIGHT OF A WOMAN TO DECIDE WHETHER OR NOT TO TERMINATE HER PREGNANCY

The right of every individual to be free from governmental interference in the exercise of personal procreative decisions has long been recognized as a fundamental liberty protected by the United States Constitution. *See*, *e.g.*, *Carey v. Population Services International*, 431 U.S. 678 (1977); *Eisenstadt v. Baird*, 405 U.S. 438 (1972); *Griswold v. Connecticut*, 381 U.S. 479 (1965). This Court has made clear that the constitutional right to privacy is "broad enough to encompass a woman's decision whether or not to terminate her pregnancy." Roe v. Wade, 410 U.S. 113, 153 (1973). This right to reproductive choice "protects the woman from unduly burdensome interference with her freedom to decide to terminate her pregnancy." Maher v. Roe, 432 U.S. 464, 473-74 (1977).

Consistent with these principles, the Court has invalidated government imposed restrictions that run afoul of this constitutional standard. In Doe v. Bolton, 410 U.S. 179 (1973), for example, a state law requiring that all abortions be approved in advance by a hospital abortion committee was held unconstitutional because the limitation was "unduly restrictive of the patient's rights and needs." 410 U.S. at 198. In Planned Parenthood v. Danforth, 428 U.S. 52 (1976), spousal and parental consent requirements could not pass constitutional muster because the state did not have the authority to "give a third party an absolute, and possibly arbitrary, veto over the decision of the physician and his patient to terminate the patient's pregnancy." 428 U.S. at 74. See also Bellotti v. Baird, 443 U.S. 662 (1979).

The limitations on abortions imposed by the challenged restrictions in the trilogy of cases now before the Court similarly attempt to circumscribe a woman's behavior and significantly impair the exercise of her fundamental right to decide whether to bear a child. These restrictions cannot be dismissed as "not burdensome or chilling." Planned Parenthood v. Danforth, 428 U.S. at 66, citing 392 F. Supp. at 1374. Nor can they be characterized as merely "state encouragement of . . . childbirth," Maher v. Roe, 432 U.S. at 475, or described as placing "no obstacles in the pregnant woman's path to an abortion." 432 U.S. at 474. See also Harris v. McRae, 448 U.S. 297 (1981). The statutory schemes enacted by Missouri, Virginia and Akron, Ohio forcefully inject government into a constitutionally protected decision-making process, riding roughshod over individuals' most private decisions. They are aimed at coercing a woman not to terminate her pregnancy by placing obstacles directly in her path.

A. For Many Women, The Challenged Regulatory Schemes Effectively Eliminate The Right To Decide To Terminate A Pregnancy

Although benign sounding on its face, the requirement that a second trimester abortion be performed in a hospital effectively eliminates, for many women, the ability to exercise their fundamental right to reproductive choice. In Missouri, Virginia and Akron, Ohio, as in many areas of this country, there are few, if any, hospitals that perform second trimester abortions. Regulations requiring that all second trimester abortions be performed in hospitals effectively eliminate the right to decide to terminate a pregnancy when there are no hospitals to provide such medical care.

For example, unrebutted testimony in the Akron case revealed that there were only two hospitals in Akron performing second trimester abortions, and during 1977, only nine second trimester abortions were performed in these two hospitals. Akron Center for Reproductive Health, Inc. v. City of Akron, 651 F.2d 1198 (6th Cir. 1981). Many Akron women seeking second trimester abortions were referred to clinics in Cleveland, Ohio and in the state of Michigan. 651 F.2d at 1209. In Planned Parenthood Association v. Ashcroft, No. 79-4142, slip op.

at 10 (W.D. Mo. Oct. 2, 1981), aff'd, 664 F.2d 687 (8th Cir. 1981), the district court concluded that the effect of Missouri's in-hospital requirement was to render unavailable a common method of second trimester abortions in the state.[4] Similarly, testimony in Simopoulos v. Commonwealth of Virginia, 221 Va. 1059, 277 S.E.2d 194 (Sup. Ct. 1981), demonstrated that only two hospitals in Northern Virginia performed second trimester abortions.

---

[4] On remand from the Eighth Circuit Court of Appeals in Planned Parenthood Ass'n v. Ashcroft, 655 F.2d 848 (8th Cir. 1981), the district court found that the in-hospital requirement in Missouri did in fact result in the performance of fewer second trimester abortions. Planned Parenthood Ass'n v. Ashcroft, No. 79-4142, slip op. at 9. The district court there had the benefit of reviewing expert testimony comparing the incidence of abortions in Missouri in two recent consecutive years, one without and one with the in-hospital requirement. Id. at 9 n.14 & 15 and text.

Nor is this picture unique to Missouri, Virginia or Akron, Ohio. In Louisiana, for example, no hospitals perform abortions after the first trimester. Margaret S. v. Edwards, 488 F. Supp. 181, 192 (E.D. La. 1980). A recent national survey indicated that less than one-third of all hospitals in the United States perform abortions after the first trimester.[5] Henshaw, Forrest, Sullivan, Tietze, "Abortion Services in the United States, 1979 and 1980," 14 FAM. PLAN. PERSP. Jan.-Feb. 1982, at 5 (1982) [hereinafter cited as "Henshaw"].

Where hospitals are unavailable to perform a second trimester abortion, a government imposed hospitalization requirement essentially acts as a governmental veto of a woman's decision to seek an abortion.[6] It operates as the kind of unauthorized, arbitrary governmental usurpation of a woman's constitutionally guaranteed right to decide to terminate her pregnancy, consistently condemned by this Court. Planned Parenthood v. Danforth, 428 U.S. 52 (1976); Bellotti v. Baird, 443 U.S. 622 (1979).

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[5] Even where hospital facilities are available, the increased financial cost may put the abortion beyond the reach of many women. See discussion infra.

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[6] Despite this dramatic unavailability of hospital facilities, twenty-one states have acted to require hospitalization for second trimester abortions. Conn. Agencies Regs.§ 19-13-D54 (1973); Ga. Code Ann. § 26-1202(b) (1973); Hawaii Rev. Stat. § 453-16(a)(2) (1970); Idaho Code Ann. 18-608.2 (1973); Abortion Law of 1975, Sec. 18-24, Ill. Rev. Stat. ch. 111 1/2, § 84 and Rules 12.6 and 12.61 (1977); Ind. Code 35.1-58.5(b)(2) (1974); Ky. Rev. Stat. § 311.760(2) (1974); La. Rev. Stat. Ann. § 1299.35.3 (West 1981); Mass. Gen. Laws Ann. ch. 112, § 12N(2)(West 1974); Mich. Admin. Code R.325.3851 (1979); Mo. Ann. Stat. § 188.025 (Vernon 1978); Mont. Code Ann. § 94-5-618 (1974); Nev. Rev. Stat. 442.250.2 (1981); N.J. Admin. Code, tit. 13 § 13, § 35-7.2 (1978); N.Y. Pub. Health Law § 4164 (1974); N.D. Cent. Code ch. 14-02:1-04.2 (1981); Okla. Stat. tit. 63 § 1-731.B (1978); Tenn. Code Ann. § 39-301(e) (1981); Utah Code Ann. § 76-7-302(2) (1974); Va. Code § 18.2-73 (1975); Wis. Admin. Code, § Chap. Med. 11.05 (1978).

B. Where The Challenged Restrictions Do Not Totally Eliminate The Right of a Woman To Decide To Terminate a Pregnancy, They Unduly Burden Her Exercise of This Constitutionally Protected Right

Those challenged provisions that do not operate to totally eliminate the ability of a woman to decide to terminate her pregnancy nonetheless erect significant obstacles to the exercise of her right by imposing a mandatory waiting period, requiring attending physician counseling and establishing controlled consent procedures. This is also the consequence of the hospitalization requirement in those areas where hospital facilities exist but are totally inadequate. These restrictions cause unnecessary delays in the performance of abortions; jeopardize the health of women who decide to terminate a pregnancy; and subtantially increase the financial costs of abortion, thereby limiting the ability of many women to undergo a safe, legal abortion procedure. They represent deliberate governmental intrusion into the constitutionally protected realm of personal decision-making.

1. The mandatory waiting period and the hospitalization requirements operate to cause unnecessary and health endangering delays in the performance of abortions.

Although advanced as a benevolent "cooling off" period, the mandatory waiting period required by the Akron ordinance injects the government directly into the personal decision-making process reserved to the woman and her physician. The decision to seek an abortion is made after extensive consultation and consideration. See Women's Community Health Center, Inc. v. Cohen, 477 F. Supp. 542, 551 (D. Me. 1979). It is not made precipitously or irresponsibly as the language of the challenged legislation might have one think. Yet, once the decision has been reached, the mandatory waiting period temporarily forecloses the availability of an abortion. It is "direct state interference" with a woman's abortion decision. Maher v. Roe, 432 U.S. at 473-75, quoted in

Planned Parenthood League v. Bellotti, 641 F.2d 1006, 1014 (1st Cir. 1981).

Although the Akron restriction challenged herein explicitly imposes a 24-hour delay between the time a woman signs the consent form and undergoes the abortion, in reality the delay it causes will be far greater. The evidence in Akron showed that no city clinic performed abortions more than three times a week. Thus, a 24-hour waiting period may actually mean a minimum delay of two to four days. 651 F.2d at 1201. See also Planned Parenthood League v. Bellotti, 641 F.2d at 1014; Charles v. Carey, 627 F.2d 772, 785 (7th Cir. 1980). Especially for women who must travel to the abortion facility, this extended delay can be a severe hardship. Such a scheme necessarily imposes

> burdens in terms of time, money, travel and work schedules; for many women, particularly the poor, the rural, and those with pressing obligations, these burdens will be substantial.

Planned Parenthood League v. Bellotti, 641 F.2d at 1015.

In addition, the second trimester hospitalization requirement, where not an insuperable barrier, similarly causes for many women a significant delay in obtaining medical care. As discussed at Point I, supra, hospital facilities are unavailable in many places, and where available, at best are inadequate. As a result, even where a facility can be found, travel time and the time it takes to make appropriate arrangements (e.g., locating the hospital; scheduling hospital space availability; accommodating the woman's family and employment responsibilities) frequently result in delaying performance of the abortion. Donovan, "Analysis: Courts Rejecting 'Maternal Health' Rationale for Hospitalization for All Mid-Trimester Abortions," 9 FAM. PLAN./POPULATION REP. Dec. 1980, at 91 (1980) [hereinafter referred to as "Donovan"]. The adverse impact of travel necessitated by hospitalization requirements and the significant burden thereby imposed results in a significant relationship between a woman's distance from an abortion facility and the likelihood that she will obtain an abortion. Margaret S. v. Edwards, 488 F. Supp. at 193-94 nn. 33 & 39.

As with any medical procedure, delay operates to increase the medical risk. The earlier in the pregnancy an abortion is performed, the lower the risk of complications or death. Courts have recognized that any risk to the woman presented by the abortion procedure increases the later the abortion is performed, affecting both her mental and physical health. See e.g., Planned Parenthood Association v. Ashcroft, 483 F. Supp. 679, 696 (W.D. Mo. 1980), aff'd in pertinent part, 655 F.2d at 866; Women's Community Health Center, Inc. v. Cohen, 477 F. Supp. at 551. Even a delay of two to seven days can pose a major health risk to women undergoing abortions. Akron Center for Reproductive Health, Inc. v. City of Akron, 651 F.2d 1198 (Tr. I, 70, 82; III, 167-68).[7]

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[7] Expert testimony presented to the trial court in Akron indicated that generally, every week of delay beyond eight weeks' gestation increases the risk of morbidity by 20% and of mortality by 50%. Akron Center for Reproductive Health, Inc. v. City of Akron, 651 F.2d 1198 (Tr. IV, 156-57).

These serious consequences of delay must, however, be viewed in the context of the overall risks associated with pregnancy, childbirth, and abortion. All pregnancies pose health risks. These risks range from injury from falls occasioned by the unusual weight distribution of advancing pregnancy to death from hemorrhage, pulmonary embolism and toxemia, among other causes. McRae v. Califano, 491 F. Supp. 630, 668-71 (E.D.N.Y. 1980). The health problem is particularly acute for indigent pregnant teenagers, who suffer from higher maternal mortality rates and are more likely to suffer health complications from pregnancy. See McRae v. Califano, 491 F. Supp. at 680-81; Alan Guttmacher Institute, 11 Million Teenagers 23 (1976).

In fact, the risk of death from childbirth is significantly greater than the risk of death from abortion. The Court in Roe v. Wade, 410 U.S. 113 (1973), cited medical data as evidence that maternal mortality rates for early abortions "appear to

(Footnote continued)

Thus, by causing delays in the abortion procedure the challenged restrictions force women to jeopardize their health.

2. The controlled consent and attending physician counseling requirements interfere with medical judgments about a woman's care and have a direct, detrimental impact on a woman's health.

By intruding directly into the decision-making process at a critical time, the controlled consent and attending physician counseling requirements of the Akron ordinance are aimed at influ-

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be as low as or lower than the rates for normal childbirth" and concluded that in early abortion, "maternal mortality in abortion *may be* less than mortality in normal childbirth." *Id.* at 149, 163 (emphasis added). More recent statistics make clear that abortion is substantially safer than childbirth. *McRae v. Califano*, 491 F. Supp. at 65. Mortality in childbirth for white women in 1974 was 10 per 100,000 live births; mortality in abortion was 0.5. For "black and other" women, mortality in childbirth was 35.1 per 100,000 live births; in abortion, 2.4. *Id.*

encing the woman to continue her pregnancy. The government seeks to do this regardless of the woman's own decision-making choices, and heedless of the fact that the pregnancy may be life endangering or health-threatening.

The consent restriction challenged in Akron prescribes a script to be read, word-for-word, by the attending physician.[8] The provisions substitute the legislature's medical judgment for that of the attending physician. Not only does this straitjacket the physician's exercise of medical judgment, but its effect is to encumber the exercise of

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[8] In pertinent part, the ordinance requires the physician to tell a woman:

> (3) [t]hat the unborn child is a human life from the moment of conception and that there has been described in detail the anatomical and physiological characteristics of the particular unborn child at the gestational point of development at which time the abortion is to be performed, including, but not limited to, appearance, mobility, tactile sensitivity, including pain, perception or response, brain and heart function, the presence of internal organs and the presence of external

(Footnote continued)

> members;
>
> (4) [t]hat her unborn child may be viable, and thus capable of surviving outside of her womb, if more than twenty-two (22) weeks have elapsed from the time of conception, and that her attending physician has a legal obligation to take all reasonable steps to preserve the life and health of her viable unborn child during the abortion;
>
> (5) [t]hat abortion is a major surgical procedure, which can result in serious complications, including hemorrhage, perforated uterus, infection, menstrual disturbances, sterility and miscarriage and prematurity in subsequent pregnancies; and that abortion may leave essentially unaffected or may worsen any existing psychological problems she may have, and can result in severe emotional disturbances.

AKRON, OH., ORDINANCE No. 160 § 1870.06B(3),(4),(5) (1978).

the woman's constitutionally protected right "by placing obstacles in the path of the doctor upon whom she was entitled to rely for advice ...." Whalen v. Roe, 429 U.S. 589, 604 n.33 (1977), quoted in Akron Center for Reproductive Health, Inc. v. City of Akron, 651 F.2d 1198, 1207. See Planned Parenthood v. Danforth, 429 U.S. 52 (1976).

The challenged restriction requires the woman to be "informed" of "facts" that are incorrect,[9] prejudicial[10] and irrelevant.[11] Rather than provide necessary information, the restrictions are calculated to inflict emotional distress, anxiety or physical

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[9] See Planned Parenthood Ass'n v. Ashcroft, 655 F.2d at 868 (physicians' testimony that they do not believe there are long-term physical and psychological effects of abortion); Charles v. Carey, 627 F.2d at 784 (medical testimony characterizing possibility of "organic pain" to fetus as "medically meaningless, confusing, [and] medically unjustified"); Leigh v. Olson, 497 F. Supp. 1340, 1345 (D.N.D. 1980) (medical experts dispute validity of statement that abortion increases the risks of sterility, premature births, tubal pregnancies and still births in future pregnancies); Wynn v. Scott,

(Footnote continued)

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449 F. Supp. 1302, 1317 (N.D. Ill. 1978) (studies have not supported statement that there is danger of subsequent sterility).

[10] See Planned Parenthood League v. Bellotti, 641 F.2d at 1021 (fetal descriptions and information on medical complications would cause many women emotional distress, anxiety, guilt or physical pain which might influence the decision, especially for those who were rape victims or who carried a potentially deformed fetus); Charles v. Carey, 627 F.2d at 784 (mandatory information was found to cause "cruel and harmful stress to . . . patients"). See also Planned Parenthood League v. Bellotti, 641 F.2d at 1022 (purpose of required information more moral than factual; "[t]he state may not add to its presentation of material facts such a moral overlay, an attempted imposition of ideas that is particularly objectionable in connection with the exercise of fundamental rights").

[11] See Planned Parenthood v. Danforth, 428 U.S. at 67 n.8 (consent requirement limited to "the giving of information . . . as to just what would be done and as to its consequences"); Planned Parenthood League v. Bellotti, 641 F.2d at 1021-23 (information must be material to medically relevant considerations).

trauma.[12] Planned Parenthood League v. Bellotti, 641 F.2d at 1021; Leigh v. Olson, 497 F. Supp. at 1345. Indeed, in addition to believing that some of the required information is detrimental to the best health interests of their patients, medical experts assert that the risks from abortion may be increased due to the woman's heightened tension and anxiety. Planned Parenthood Association v. Ashcroft, 655 F.2d at 868.

The Akron ordinance makes no exception, but inflicts the punitive "required reading" on all women, far surpassing any conceivable interest the state may have in assuring that the decision is knowingly made. See Charles v. Carey, 627 F.2d at 784.

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[12] E.g., the majority of women would not want to hear fetal descriptions prior to an abortion and most doctors would not consider it good medical practice to provide them. Planned Parenthood League v. Bellotti, 641 F.2d at 1022.

Denominating the attending physician as the one who must provide the prescribed "information" similarly ignores the health needs of the woman. This requirement forces the physician to provide the information even though, in his or her professional judgment, a trained counselor would be much more effective in imparting certain information and obtaining consent. Women's Medical Center of Providence, Inc. v. Roberts, 530 F. Supp. 1136, 1147-48 (D.R.I. 1982); see Leigh v. Olson, 497 F. Supp. at 1346. It denies the physician this flexibility and may deprive the woman of critically important support at an emotionally trying time.

3. The challenged restrictions increase the financial and emotional costs for the woman deciding to terminate her pregnancy.

The challenged restrictions further burden the exercise of the constitutional right to reproductive decision-making by unnecessarily increasing the financial costs of such medical care. The cost of having a second trimester abortion performed in a hospital on an inpatient basis is not insubstantial. It has been found to be at least twice the cost of the same procedure performed in an outpatient clinic. Akron Center for Reproductive Health, Inc. v. City of Akron, 651 F.2d at 1209; Planned Parenthood Association v. Ashcroft, slip op. at 7 n.9,11 and text (W.D. Mo. Oct. 2, 1981); Donovan, 91.[13]

The travel frequently required to comply with hospitalization requirements and mandatory waiting periods imposes an additional significant economic burden on the abortion decision because of the expenses incurred for transportation, lodging and child care, as well as because of the loss of income due to the additional time required. These economic impediments to the decision to end a pregnancy by abortion are particularly critical in light of federal and state restrictions on the public funding of abortions.[14]

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[13] On remand in Ashcroft, the district court found that the additional expense of having a second trimester abortion performed in a hospital as compared to a clinic, ranged from $150 to $1,650. Planned Parenthood Ass'n v. Ashcroft, slip op. at 7 n.9 and text (W.D. Mo. Oct. 2, 1981).

Although the Court has recognized that a woman's fundamental interest in personal privacy protects her choice of whether to continue or to terminate her pregnancy, Roe v. Wade, 410 U.S. 113 (1973), in reality, only those women able to pay the cost of their medical care can effectuate their constitutional choice between these two alternatives free from state interference.[15] Where the physician cannot afford to work for no fee, and the woman cannot afford to pay, safe medical abortion is not a realistic alternative. See Singleton v. Wulff, 428 U.S. 106, 118-19 n.7 (1976). Governmental regulations designed to unnecessarily increase the cost of abortions, combined with virtual elimination of public funding, undoubtedly will have the intended effect upon many women: lacking feasible alternatives they will be forced to continue their unwanted pregnancies. And, for some, this will mean the unwilling continuation of a life-endangering or health threatening pregnancy. The merger of increased regulation and decreased funding will have an additional, critical effect: emotionally distraught and unable to raise the money for a legal abortion, some women will turn in desperation to less costly and less safe illegal abortions.[16] The most recent statistics available show that in 1977, for the first time since 1972, reported deaths due to illegal abortions increased.[17]

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[14] Indeed the federal government has acted to deny funds for almost all abortions precisely because it wishes to subvert the reproductive choice of women seeking to terminate their pregnancies. For example, the chief sponsor of the funding restriction, Rep. Henry Hyde, declared his intention "to forbid the use of Federal funds to promote or encourage anyone to have an abortion," 122 CONG. R. H26784 (daily ed. August 10, 1976) (statement of Rep. Hyde). See also McRae v. Califano, 491 F. Supp. 630, 640-46 (E.D.N.Y. 1980).

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[15] As the Court recognized in Maher v. Roe, 432 U.S. 464, 474 (1977), by funding the childbirth alternative for the Medicaid-dependent woman and excluding the abortion alternative, the state deliberately influences the woman's reproductive choice. See Harris v. McRae, 448 U.S. 297 (1980).

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[16] U.S. Dep't of Health, Education and Welfare, Center for Disease Control, Abortion Surveillance Annual Summary 1977 12-14 (1979).

[17] *Id*. at 1. *See* Petitti and Cates, "Restricting Medicaid Funds for Abortions: Projections of Excess Mortality for Women of Childbearing Age," 67 *Am. J. Pub. Health* 860, 861 (1977).

Still other women will risk their lives by attempting one of the numerous dangerous methods of self-abortion.[18]

Thus, the increased emotional, health and financial costs resulting from the challenged restrictions impermissibly jeopardize and burden the health and well-being of women.

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[18] "Among the non-medical procedures used for inducing abortion," according to the National Academy of Sciences Institute of Medicine, "are eating or drinking quinine or other drugs, introduction of chemicals into the vagina, and mechanical methods such as inserting blunt or sharp instruments into the uterus through the vagina. The drugs quite often lead to poisoning or vomiting so intense that it results in dehydration and eventual death unless fluid replacement compensates the loss. Inserting chemicals or instruments in the vagina or uterus can lead to: (1) infection; (2) injury to the membranes of the vagina; (3) perforation of the uterus with the possibility of injury to other organs in the abdominal area; (4) bleeding due to retained fetal or placental tissue; and (5) air embolism." National Academy of Sciences Institute of Medicine, Legalized Abortion and Public Health 64 (1975).

II

THE CHALLENGED RESTRICTIONS DO NOT WITHSTAND CONSTITUTIONAL SCRUTINY

A. Strict Scrutiny Is Required Where, As Here, The Challenged Restrictions Burden A Woman's Exercise Of Her Fundamental Right To Terminate Her Pregnancy

This Court has repeatedly held that a statutory scheme which infringes upon a woman's fundamental right to decide to terminate her pregnancy by abortion can survive constitutional scrutiny only if justified by a compelling state interest that is narrowly drawn to express the legitimate state interests at stake.[19]

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[19] The strict scrutiny standard is called into play if two conditions exist. First, the obstacle to the exercise of the fundamental right must have been created by the government. Maher v. Roe, 432 U.S. 464 (1977). Second, the restriction must impinge upon the exercise of the fundamental right. Planned Parenthood v. Dan-

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Roe v. Wade, 410 U.S. at 155. The Court in Roe accepted the assertion by the State of Texas that there are legitimate state interests during the pregnancy in the health of the woman and in protection of potential fetal life.[20] Finding these interests to be separate and distinct, and conflicting with the woman's right to decide to terminate a pregnan-

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forth, 428 U.S. 52 (1976). Since both conditions are present, the obstacle created by the Missouri, Virginia and Akron, Ohio legislation can stand only if justified by a compelling state interest narrowly drawn. Roe v. Wade, 410 U.S. 113 (1973).

[20] This Court declined to define the point at which life begins. "When those trained in the respective disciplines of medicine, philosophy, and theology are unable to arrive at any consensus, the judiciary, at this point in the development of man's knowledge, is not in a position to speculate as to the answer." Roe v. Wade, 410 U.S. at 159. The Court rejected the attempt of Texas to define "life" as beginning at conception and thus to justify state interference throughout the pregnancy.

cy, the Court divided pregnancy into trimesters, defining the legitimate state interest, and therefore the parameters of state interference, at each juncture.

During the first trimester of pregnancy, neither the state's interest in the woman's health nor in potential fetal life can justify *any* state interference with the woman's right to decide. In the second trimester, state intrusion is permissible only if it promotes the state's legitimate interest in ensuring the woman's health. And in the third trimester, the state's interest in the potential life of the fetus is sufficient to justify significant intrusion, even a total proscription of abortion, unless an abortion is necessary to preserve the life or health of the woman. See Roe v. Wade, 410 U.S. at 163-64; Harris v. McRae, 448 U.S. at 313. Thus, protecting the woman's health is the paramount state interest in the second and third trimesters of pregnancy. When measured against this interest, the challenged restrictions must fail, for they are nothing more than a thinly veiled attempt to limit the availability of abortions, in essence to accomplish through the back door what the Court forbade in Roe.

B. The Challenged Restrictions Cannot Withstand Strict Scrutiny And Are Invalid

1. The second trimester hospitalization requirement is not reasonably related to the state's legitimate interest in protecting the woman's health.

As discussed fully at Point I, supra, the requirement that all second trimester abortion procedures be performed in licensed hospital facilities has the effect of totally eliminating or significantly decreasing the availability of second trimester abortions. There can be no greater example of direct state interference infringing on the exercise of a fundamental right than denial of access to the means necessary to effectuate that right. Further, since these requirements drastically limit the availability of the two safest and most common methods of second trimester abortions,[21] the state's asserted interest

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[21] The techniques specifically addressed in these cases are the dilatation and evacuation and saline installation procedures. Recent medical studies demonstrate and courts have

(Footnote continued)

in protecting the woman's health is revealed to be not a justification, but a transparent excuse.

In view of the demonstrable burden placed on the abortion decision by requiring all second trimester abortions to be performed in hospitals, the state must show that such restriction promotes

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found, that D & E is now the most used and safest procedure for early second trimester abortions, *Margaret S. v. Edwards*, 486 F. Supp. at 195; *Planned Parenthood Ass'n v. Ashcroft*, 655 F.2d at 856; *Wolfe v. Stumbo*, 519 F. Supp. 22, 25 (W.D. Ky. 1980); *see* *Foe v. Dep't of Public Health*, No. 78 C 4126 slip. op. (N.D. Ill., May 11, 1981).

Use of the saline method was upheld by this Court in *Planned Parenthood v. Danforth*, 428 U.S. 52 (1976). In support of its holding, the Court found that saline is "an accepted medical procedure"; if utilized in a "substantial majority . . . of all post-first trimester abortions" it is "safer, with respect to maternal mortality, than even the continuation of the pregnancy until normal childbirth." 428 U.S. at 77, 78. *See* *Colautti v. Franklin*, 434 U.S. 379, 398-99 (1979).

its interest in the woman's health. To satisfy this constitutional burden, "the State must show . . . that only the full resources of a licensed hospital, rather than those of some other appropriately licensed institution, satisfy [its] health interests." Doe v. Bolton, 410 U.S. at 195.

The evidence submitted in each case before the Court does not support a conclusion that second trimester hospital abortions are significantly less dangerous to a woman's health than comparable procedures performed in non-hospital clinics. To the contrary, the records below amply demonstrate that the second trimester abortion methods used in these cases -- dilatation and evacuation and saline instillation -- can safely be performed outside a hospital. Akron Center for Reproductive Health, Inc. v. City of Akron, 651 F.2d at 1209; Planned Parenthood Association v. Ashcroft, 664 F.2d at 690 (8th Cir. 1981); Simopoulos v. Commonwealth of Virginia, 221 Va. at 1075-76, 277 S.E.2d at 202-03.

It is particularly significant that the American College of Obstetricians and Gynecologists, reversing an earlier position, has concluded that second trimester abortions may be safely performed in non-hospital facilities. See American College of Obstetricians and Gynecologists, Manual of Standards for Obstetrician Gynecological Services at

16 (1982). ACOG has made clear its approval of the performance of abortions on an outpatient basis through the 18th week from the last menstrual period. The American Public Health Association advises that "[r]equirements that all abortions after [the first trimester] be performed in hospitals increase the expense and inconvenience to the woman without contributing to the safety of the procedure." Donovan at 91-92. Similarly, other medical experts have concluded that both procedures can be safely performed in non-hospital facilities. *See* Cates, Grimes, "Deaths from Second Trimester Abortion by Dilatation and Evacuation: Causes, Prevention, Facilities," 58 *Obstetrics and Gynecology* 401

(1981)[22]; Schulman, Kaiser, Randolph, "Outpatient Saline Abortion," 37 Obstetrics and Gynecology 521 (1971).

In view of the medical evidence demonstrating the safety of outpatient second trimester abortions, it is obvious that restrictions which require all second trimester abortions to be performed in hospitals are not reasonably related to the preservation of the woman's health, nor are they narrowly drawn to avoid overbroad interference with a woman's decision whether to bear a child. Planned Parenthood Association v. Ashcroft, 655 F.2d at 853-57; Wolfe v. Stumbo, 519 F. Supp. at 24-25; Margaret S. v. Edwards, 488 F. Supp. at 194-96. Thus, there is no medical justification for the restriction.

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[22] These authors also suggest that policymakers reconsider laws requiring all second trimester abortions to be performed in hospitals.

Moreover, by imposing a hospitalization requirement, the state is deliberately endangering a woman's health. The hospitalization requirement operates to make second trimester abortions unavailable for many women, as discussed at Point I, supra, and adds the burden of time delays for many more. As discussed at Point I, supra, each day of delay increases the woman's health risk. This puts the state's restrictive action in a head-on collision with its acknowledged interest in protecting the woman's health. Far from serving the woman's health interest, the hospitalization restriction actually endangers the woman's health by effectively "proscrib[ing] the safest alternative presently available for post-first trimester abortions." Margaret S. v. Edwards, 488 F. Supp. at 193. This result may, "as a practical matter . . . forc[e] a woman and her physician [to continue her pregnancy or] to terminate her pregnancy by methods more dangerous. . . ." Planned Parenthood v. Danforth, 428 U.S. at 79.

Therefore, this restriction is an "unreasonable [or] arbitrary regulation designed to inhibit and having the effect of inhibiting" the vast majority of abortions after the first trimester. Planned Parenthood v. Danforth, 428 U.S. at 79. Accordingly, it is a restriction that plainly contravenes the constitutionally protected right of women seeking second trimester abortions, and this Court's holdings in Roe v. Wade, Doe v. Bolton and Planned Parenthood v. Danforth.

2. The mandatory consent, attending physician counseling and waiting period restrictions constitute unjustified state interference in the exercise of a fundamental right and are unconstitutional.

   a. The challenged restrictions are wholly impermissible when applied in the first trimester of pregnancy.

Roe v. Wade makes clear that there can be no interference with the woman's decision-making process during the first trimester of a pregnancy. 410 U.S. at

163. The challenged consent, attending physician counseling and waiting period restrictions directly interfere with -- indeed disrupt -- the exercise of the constitutionally protected right to abortion. As fully discussed at Point I, _supra_, these limitations impose substantial burdens on the decision to terminate a pregnancy by abortion. The restrictions add the state as a third party in the decision-making process -- invisible but present, both through words which must be spoken by a state-designated individual and through a forced "cooling off" period. These direct intrusions into the decision to undergo a first trimester abortion are

flatly contrary to the clear mandate of Roe v. Wade, and cannot stand.[23]

b. The challenged restrictions do not advance a compelling state interest when applied after the first trimester of pregnancy.

(1) The consent requirement.

Rather than furthering communication between the physician and patient to enhance understanding of the medical procedure, the mandated consent requirement in the Akron ordinance is a transparent attempt to control the woman's decision whether or not to terminate her pregnancy. It is a far cry from the consent requirement upheld by this Court in Planned Parenthood v. Danforth, 428 U.S. 52 (1976). There, the Court scrutinized and upheld a statutory restriction that required a woman, prior to obtaining a first trimester abortion, to certify in writing that her "consent is informed and freely given and is not the result of coercion." Id. at 65. "Informed consent" was construed in Danforth as:

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[23] Many lower courts have invalidated similar provisions. See, e.g., Charles v. Carey, 627 F.2d at 784-86; Women's Medical Center of Providence v. Roberts, 530 F. Supp. at 1144; Margaret S. v. Edwards, 488 F. Supp. at 212; Women's Community Health Center v. Cohen, 477 F. Supp. 542, 551-52.

> [T]he giving of information to the patient as to just what would be done and as to its consequences. To ascribe more meaning than this might well confine an attending physician in an undeserved and uncomfortable straitjacket in the practice of his profession.

428 U.S. at 67 n.8; see Freiman v. Ashcroft, 584 F.2d 247 (8th Cir. 1978),

aff'd, 440 U.S. 941 (1979). The City of Akron has attempted to expand beyond recognition the exception carved out in Danforth -- building from this exception a scheme which would swallow the rule in Roe v. Wade.

The Akron restriction, unlike the provision in Danforth, dictates to the physician precisely what must be said. Apparently, in the City of Akron, being "informed" means a woman is to be told what the government decides she should be told, rather than what her physician believes is necessary to the making of a truly informed decision. Similar restrictive consent directions have been rejected by the courts, finding the language to be an intrusion into the physician-patient relationship that is not justified by the state's interest in preserving the woman's health.

The importance of a sensitive and individualized approach to the obtaining of consent was aptly described by the U.S. Court of Appeals in Planned Parenthood League v. Belotti:

> [T]he uncontradicted expert testimony . . . indicated that requiring women seeking abortions to read this information ["description of the stage of development of the unborn child"] would cause many of them emotional distress, anxiety, guilt, and in some cases increased physical pain -- and it is of course by its impact on women in that stressful situation, rather than on judges or other detached readers, that the information must be measured.

641 F.2d at 1021.

The likelihood of negative effects on the woman's health from such consent requirements was recognized by both of the lower courts in the Planned Parenthood Association v. Ashcroft litigation. 655 F.2d at 868. As discussed fully at Point I, supra, numerous other courts have examined statutes prescribing the content of the information to be given to a woman seeking an abortion. In none of those cases did the court find a positive relationship between the required information and the woman's health; indeed, courts have tended to find that such information can be damaging to health interests. See, e.g., Leigh v. Olson, 497 F. Supp. at 1345.

These elaborate prescriptions for controlled consent inject the state into the decision-making process by placing the doctor in the "undesired and uncomfortable straitjacket" warned against in _Danforth_, and are unconstitutional. _Akron Center for Reproductive Health, Inc. v. City of Akron_, 479 F. Supp. at 1203, _aff'd in pertinent part_, 651 F.2d at 1207.

(2) The attending physician counseling requirement.

The attending physician counseling restriction prescribes a course of conduct without regard for the physician's professional judgment or the woman's medical needs. It applies to every woman who seeks an abortion, whether or not she has been counseled by her private physician prior to referral to a clinic for the specialized services it provides. This state-imposed obligation creates the kind of "straitjacket" found objectionable by this Court in Danforth, and is impermissble under Roe. Akron Center for Reproductive Health, Inc. v. City of Akron, 479 F. Supp. at 1203, aff'd in pertinent part, 651 F.2d at 1207.

The attending physician requirement is not only burdensome, but inimical even to meet the asserted need: protection of the woman's health. Charles v. Carey, 627 F.2d at 784. Thus, strict scrutiny reveals no compelling state interest to justify this restriction.

(3) The mandatory waiting period requirement.

Similarly, statutes which fix inflexible requirements that abortions be postponed do not advance the state's interest in preserving the woman's health, and are thus unconstitutional. As discussed at Point I, supra, a state-mandated delay in the performance of an abortion deprives a woman of the right to end her pregnancy after she has voluntarily and knowingly decided to do so. This delay often, as noted at Point I, supra, results in postponing the abortion for a substantially longer period of time, since many facilities provide abortion services only once or twice a week. Such a delay can increase the risk to the woman's health. The fact that imposition of a waiting period exacerbates, rather than ameliorates, the potential health risks has led the lower courts to invalidate such requirements. See, e.g., Planned Parenthood Association v. Ashcroft, 655 F.2d at 866 (48-hour waiting period),[24] Planned Parenthood League v. Bellotti, 641 F.2d at 1014 (24-hour waiting period); Charles v. Carey, 627 F.2d at 785 (24-hour waiting period); Margaret S. v. Edwards, 488 F.Supp. at 212 (24-hour waiting period); Women's Services, P.C. v. Thone, 483 F.Supp. 1022, 1050 (D. Neb. 1979), aff'd, 636 F.2d 206 (8th Cir. 1980), vacated and remanded on other grounds, 452 U.S. 911 (1981) (48-

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[24] The state has not sought review of this holding.

hour waiting period). This requirement reflects government attempts to coerce a woman to carry her pregnancy to term, irrespective of her physical and psychological condition; it fails to meet the strict scrutiny test.

CONCLUSION

For the foregoing reasons, the legislative provisions requiring that post-first trimester abortions be performed in hospitals, that physicians be required to convey specified information prior to obtaining a patient's consent for an abortion, that only the attending physician may counsel a patient at the stage of obtaining her consent, and that a woman must endure a mandatory waiting period after she has given her consent, should be declared unconstitutional.

Respectfully submitted,

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IN THE

Supreme Court of the United States

OCTOBER TERM, 1981

PLANNED PARENTHOOD ASSOC. OF
KANSAS CITY, MISSOURI, INC., NAIM S. KASSAR,
M.D., REPRODUCTIVE HEALTH SERVICES AND
ALLEN S. PALMER, D.O.,
Petitioners,

vs.

JOHN ASHCROFT, ATTORNEY GENERAL OF THE
STATE OF MISSOURI, AND RALPH L. MARTIN,
PROSECUTING ATTORNEY OF JACKSON
COUNTY, MISSOURI,
Respondents.

ON A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE EIGHTH CIRCUIT

BRIEF AMICUS CURIAE OF THE NATIONAL RIGHT TO LIFE COMMITTEE, INC., IN SUPPORT OF RESPONDENTS, JOHN ASHCROFT, ET AL.

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No. 81-1255

IN THE

Supreme Court of the United States

OCTOBER TERM, 1981

PLANNED PARENTHOOD ASSOC. OF
KANSAS CITY, MISSOURI, INC., NAIM S. KASSAR,
M.D., REPRODUCTIVE HEALTH SERVICES AND
ALLEN S. PALMER, D.O.,
Petitioners,

VS.

JOHN ASHCROFT, ATTORNEY GENERAL OF THE
STATE OF MISSOURI, AND RALPH L. MARTIN,
PROSECUTING ATTORNEY OF JACKSON
COUNTY, MISSOURI,
Respondents.

ON A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE EIGHTH CIRCUIT

NOTE

This Brief Amicus Curiae is filed with the consent of all parties to this appeal. A letter from each attorney stating this consent has been filed herewith with the Clerk of this Court.

STATEMENT OF INTEREST OF AMICUS CURIAE NATIONAL RIGHT TO LIFE COMMITTEE, INC.

The members of the National Right to Life Committee, Inc. have been the prime supporters of laws restricting abortion within the guidelines of *Roe v. Wade*, 410 U.S. 113 (1973) and *Doe v. Bolton*, 410 U.S. 179 (1973). In addition to being opponents to abortion on demand, the National Right to Life Committee, Inc. is concerned about maintaining the integrity of the family unit in the context of the abortion decision. As a result, members of the National Right to Life Committee, Inc. have been the prime supporters of laws requiring parental involvement in the abortion decisions of their minor daughters. The Missouri's parental or court consent requirement for immature, unemancipated minors herein is the result of lobbying, in great part, by the members of the National Right to Life Committee, Inc. and its Missouri affiliate, Missouri Citizens for Life.[1] By means of this brief, the National Right to Life Committee, Inc. seeks to advance these interests by supporting the Missouri parental or court consent requirement herein.

BRIEF AMICUS CURIAE

NOTE

The Questions Presented and The Statement of the Case are omitted from this Amicus Curiae Brief since they are amply stated in the Respondents' Brief of John Ashcroft, et al.

SUMMARY OF ARGUMENT

The issue presented herein is whether the Missouri statute requiring parental or court consent for an immature unemancipated minor seeking an abortion complies with the strictures of *Roe v. Wade, supra.*

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[1] The author of this brief consulted in the drafting of the Missouri Statute herein and testified before Committees of both the Missouri House and Senate in favor of its passage.

Roe v. Wade established that the right to privacy encompasses a woman's right to decide whether or not to seek an abortion. This abortion privacy right is held by minors as well as adult women. Not all regulation of abortion, however, is unconstitutional under *Roe v. Wade.* There is no absolute right to an abortion.

Abortion has a substantially adverse impact upon minors. The most appropriate and effective resolution of the crisis of a teenage pregnancy is within the family. The minor will derive a long term benefit by the support of her parents in making the abortion decision.

Important state interests are served by requiring parental or court consent for immature unemancipated minors which include the state's interest in fostering the family structure and preserving family autonomy, the importance of the parental role and the state's interest in protecting minors against their own immaturity. These important state interests are particularly important in the abortion context since the consequences of abortion can be severe and long lasting.

The Missouri statute requiring parental or court consent of immature unemancipated minors serves these significant state interests and is narrowly drawn to serve only these interests. Mature, unemancipated minors need not obtain the consent of either their parents or a court but may obtain the right of self consent by judicial decree. Emancipated minors may consent to an abortion without parental consent or seeking judicial authorization. In addition, immature minors may petition a court, without parental knowledge, to obtain judicial consent for an abortion in their best interest. As a result, the Missouri statute is constitutional.

ARGUMENT

I

Abortion has a substantially adverse impact upon minors and can be most successfully resolved within the family.[2]

An abortion on a pregnant minor has a substantial impact, not only on her health, but upon her relationship with her family. Contrary to current beliefs, expectations and public pronouncements, abortion is neither simple nor singular in its nature, context or consequence. In 1977, twenty-eight percent of pregnancies were terminated by abortion. U.S. BUREAU OF THE CENSUS, *Perspectives on American Fertility,* NO. 70, CURRENT POPULATION REP. (1978). Abortion is now becoming a common form of ferility control. Forrest, Tertz and Sullivan, *Abortion in the United States 1976-1977,* 10 FAM. PLAN. PERSP. 271 (1978). One third of all abortions were concentrated in women under nineteen years of age. Krannick, *Abortion in the United States: Past, Present and Future Trends,* 29 FAM. REL 365 (1980). As a result over 500,000 pregnant minors, their partners, their relationships and their families will be effected by abortion this year. The adverse impact of abortion on minors and the need to resolve this crisis in the context of their families provides a compelling basis for government regulation.

The family is a powerful and effective problem solving unit. Klein and Hill, *Determination of Family Problem Solving Effectiveness,* 2 CONTEMPORARY THEORIES ABOUT THE FAMILY 492 (W.Burr et al. eds. 1979). The family has a remarkable ability to expand and contract with the development and recession of problems and needs. It is also the focus of effective decision making.

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[2] The author wishes to acknowledge the assistance of Vincent M. Rue, Ph.D., Assoc. Professor of Family Relations, California State University at Los Angeles, for his assistance with this section.

> In a society of rapid social change, problems, outnumber solutions, and the resulting uncertainties are absorbed by the members of society, who for the most part are also members of families. Because the family is the bottle-neck through which all troubles pass, no other association so reflects the strains and stresses of life. The family today is not only the focal point of frustration and tensions, but also the source for resolving frustrations and tensions...... Through its capacity for sympathy, understanding, and unlimited support, the family habilitates personalities bruised in the course of competitive daily living. R. HILL, FAMILIES UNDER STRESS (1949)

This is no less true with the challenges and responsibilities posed by a problem pregnancy.

Abortion and the problems of decision making associated with it have too often placed the highest value on the individual over relational priorities, focusing on the pregnant woman in her urgent need to make a decision. Emerging from the position that a woman has total control over her own body, women's advocates have failed to differentiate between a woman's body and the unborn child that is the product of the relationship between two people and their relationship to their families. To its ideological advocates of women's rights, the woman is assumed to be the sole factor in decision making. While this may be understandable according to archaic ideologies that excluded and exclude women's rights and needs from forthright consideration, nevertheless, this position is an overreaction. Paradoxically, such a posture runs the risk of becoming ideologically rigid and counterproductive to women in their long-term relationships to men, and relationally negative for men in their relationships with women. It is impossible to lift a pregnant woman out of her primary loyalty system, i.e., her present and future family network, for the purpose of decision making without manifesting a complementary therapeutic concern for the relationship fallout of her decision on her mate, parents, children (born and unborn), siblings, grandparents, and other significant relationships. The implications of each person's situation must be faced within their relationship system especially as crises are generated by unanticipated events like problem pregnancies. Cotrones and Krasner, *A Study of Abortion and Problems in Decisionmaking*, 3 J. MAR. AND FAM. COUNSELING 69 (1977).

A primary therapeutic goal ought to be to help the pregnant woman face the impact of her relational legacies on her present capacity to make decisions. In this sense, the present and past do indeed have consequences for the future. Therapeutically then, it is not optimum to reinforce relational evasion by family members, nor is it desirable to promote the fantasy that decision making can occur in a relational vacuum. Likewise, often ignored is the woman's unspoken wish to face her parents or mate with her ambivalence and to draw on their support, even when it comes in the form of disagreement or conflict. Rosen, Teenage Pregnancy and Parental Involvement: Changing Trends (1977) (paper to Annual Meeting of Society for the Study of Social Problems).

Then too, the pregnancy decision making drama unfolds quickly. Perhaps a pregnant woman has made a firm decision that abortion is her answer to the problem pregnancy, and perhaps she is fully accepting of that decision. However, she is apt to have made that decision under extreme pressure. Probably shocked by the knowledge that she is pregnant and realizing there is very little time to make up her mind about the abortion, she may well overreact with intense anxiety and impulsivity to her situation. To exclude communication with her mate or parents at this vital point is to deprive her unnecessarily of the resources of the family bond. Appropriate communication at this time is invaluable, helping to explore feelings, values, options and resources. R. WILSON, PROBLEM PREGNANCY AND ABORTION COUNSELING (1973).

Understanding the nature of crisis and appropriate crisis intervention is also important. Typically, an individual negotiates problems by employing a variety of problem solving mechanisms, one of which hopefully solves the problem. Before the solution occurs, the person is in a state of tension or disequilibrium, which usually does not become excessive if the state is short-lived and if the person is accustomed to such periods of tension. In a crisis, however, the tension is much greater, not only because the problem is more significant, but also because the individual's usual way of dealing with the problem offers no solution. This is particularly true in the case of a minor with a pregnancy since there very often has been no prior problem solving experience of this nature of magnitude.

The uncomfortable state in which the pregnant minor finds herself is of a much longer duration than it is in her usual problem solving activities, and she develops a feeling of helplessness and ineffectiveness. C. CHILMAN, ADOLESCENT SEXUALITY IN A CHANGING AMERICAN SOCIETY (1978). These feelings are often associated with some functional disorganization which may consist either of attepts at discharging inner tension or trial and error attempts to solve the problem. Through this mechanism, the pregnant minor may either develop new methods of dealing with her problem or fail and simply avoid a solution. The new methods of problem solving developed during the crisis are typically added to her repertoire of behaviors, and if effective, will be likely to reoccur in the future. The inability to deal with the problem, or an inadequate understanding of the nature of the problem and its causes, and/or a poor solution will considerably impair future coping abilities of the pregnant minor.

At the more general systems level, a system in crisis may be best defined as a system under such a high degree of environmental stress that both the system's ability to adapt and its ability to maintain its steady state are overwhelmed, resulting in a disorganization of the system. Halpern, Cauale, Gant and Bellamy, *A Systems-Crisis Approach to Family Treatment*, J. MARITAL AND FAM. THERAPY 87 (April, 1979). Following such disorganization the system will reorganize itself, but the potential for change is much greater in the reorganizing system than had the crisis not occurred. Thus, the potential exists that the family will be more functional after crises have been identified, verbalized, discussed, and resolved then if secrecy had prevailed. Fragmented and insulated crisis decision making, however, is overpowered by alienation and dysfunction in perception. Manderscheid, Silbergeld and Dager, *Alienation: A Response to Stress*, 5 J. CYBERNETICS 91 (1975).

So much more than a child yet so much less than an adult, an adolescent with a problem pregnancy deserves far more careful analysis and assistance than she has been afforded. All teenagers are at risk because they are in a critical stage of psychosexual development and interpersonal relationships. P. BLOS, THE ADOLESCENT PASSAGE (1979). They are socially, psychologically and educationally ill-equipped to meet the demands of adult responsibility, especially those of marriage and parenthood. Insecure about their identities as men and women and only at the beginning of heterosexual interaction, it becomes easy to discern the enormous havoc a non-marital pregnancy injects into their lives. These adolescents are ashamed, frightened, alone, and unable to communicate their predicament to others, largely because of their own fears and self-disapproval. Sometimes the victims of their own destructive game playing with their parents, Gedan, *Abortion Counseling with Adolescents*, ABORTION: THE EMOTIONAL IMPLICATIONS 102 (R. Kalmar ed. 1977), they find the crisis changes everything: relationships within the community, with parents, siblings, friends, and God, as well as their own attitude toward themselves. The loss of self-esteem can be monumental, demanding much attention and empathy. Why must this loss be irreparable within the family or orgin? And why at a time when adolescents most need potential guidance and assistance, should they be robbed of this invaluable resource?

From a number of different sources, a questioning attitude regarding parental exclusion is becoming more prevalent. The Sex Information and Education Council of the United States clearly stated: "As an isolated approach, abortion does little to help the individual work out basic conflicts about herself and may add to feelings of guilt and depression." SEX INFORMATION AND EDUCATION COUNCIL OF THE UNITED STATES, TEENAGE PREGNANCY: PREVENTION AND TREATMENT (1971). Hence, it is not unusual to see teenagers who have had an abortion return without counseling a year later with another unwanted pregnancy. The occurrence of a pregnancy often indicates a psychological need to become pregnant which is greater than the need not to be pregnant, and unless a therapeutic approach addresses itself to an understanding of that need and an adjustment of basic life situations, the need will persist and abortion will accomplish little with respect to the well-being of the individual. Sarrel, *Teenage Pregnancy*, 16 PEDIATRICS CLINCIS N. AM. 121 (1969). The same observation, of course, could be made of adoption or of marriage because of pregnancy or of keeping the baby without marriage. Indeed, if the basic factors which led to the pregnancy are not understood and are not altered, then the problem is likely to persist.

Beyond a doubt, the pregnant minor needs help in developing a "realistic plan" which takes into account her relationship with her family and the characteristics of her current living situation. In a survey of four hundred pregnant minors, one study concluded that this can best be done through actual home visits and family conferences. Parental involvement becomes all the more important when the girl's own family is a single parent family. Foster, *Pregnancy Among School Age Girls—A Local Evaluation of* *a National Problem*, 11 PUB. WELFARE 73 (1972).

To attempt to eliminate parental involvement from a pregnant minor's decision making process is both unrealistic and unnatural. It promotes a false sense of independence and a misguided notion of personal freedom. Personal freedom is only enhanced by helping people appreciate the facts of the situations they find themselves in, and encouraging them to deal with the facts in ways which permit self-acceptance and personal growth *toward* others. Ademak, *Abortion, Personal Freedom and Public Policy*, 23 FAM. COORDINATOR 411 (1974).

A clinical study of pregnant adolescents found many of the adolescent patients examined were restricted in their self-awareness, rather mechanical in their attitudes toward the expression of sex, basically lonely and isolated although members of peer groups, frequently hurt by their parent's disinterest in the pregnancy and lack of communication in the relationship, often in poor communication with their parents, and lacking reality appraisal of what it means to care for a baby. Cobliner, Schulman and Romney, *The Termination of Adolescent Out-of-Wedlock Pregnancies and the Prospects for Their Primary Prevention*, 115 AM. J. OBST. AND GYN. 432 (1973). When patients consented, interviews were held with their mothers. These interviews often were helpful in establishing much better parent-daughter communication and in working out an appropriate variety of plans for handling the pregnancy.

In addition, abortions are less distressing to the young woman if she has the psychological and financial support of both her parents and her partner. Young women also often mistakenly feel that their parents would not be able to accept their situation and that their partners would be unwilling to help them. These young women are, however, frequently mistaken about their assumption. Though parents may be shocked and upset by their daughter's pregnancy, they adapt to the situation. Whatever decision the young woman, her parents, and her partner make together, the sharing they have had in the situation probably will have beneficial effects in most instances. A secret abortion, without this prior sharing, would seem to create a psychological burden for the young woman and a barrier to her future relationships with those people in her life who are most significant to her. C. CHILMAN, *supra*.

In dealing with problem pregnancies the Consortium on Early Childbearing and Childrearing of the Child Welfare League of America has asserted that "[p]arents have a primary influence on their children's development of feelings of self-worth and ego strength. Parents are motivated to seek help in a crisis." According to the Consortium, opening lines of communication between parent and child is seen as one of the important goals of sex and parenting education programs. They added, "[a]lthough young people are often asked how they think their parents feel about it (sexuality), parents themselves are seldom asked." In communication about adolescent sexuality, the Consortium felt that often the experience provides "both parent and teenager with his or her first realization of the other as a sexual being. Frequently, parents are reassured that young people are not as 'far out' as they thought, and the young people often find their parents' values more liberal than they had anticipated." CHILD WELFARE LEAGUE OF AMERICA, PREVENTION OF ADOLESCENT PREGNANCY 18 (1974) (Consortium on Early Childbearing and Childrearing).

Perhaps the most comprehensive and current assessment of teenage problem pregnancies has recently been undertaken by the Family Impact Seminar of the Institute for Educational Leadership at George Washington University. One of the participants, Greer Litton Fox, writing on the role of the family, concluded:

> With regard to policies concerning teenage sexuality,

> the evidence from existing research suggests a rather simple cardinal principle: ways of involving the parent or parents of teens must be developed; implemented as a core component of the program; and evaluated, whether the specific program is primary prevention, sex education, contraceptive service provision, or pregnancy and post-partum assistance. Policies that ignore familiar support, and undermine, rather than supplement, the efforts and *effectiveness* of parents are likely to yield programs that are wasteful, inefficient, and ineffective; and, what is more serious, are likely to do a considerable disservice to the teenagers about whom we are so concerned. Fox, *The Family's Role in Adolescent Sexual Behavior*, TEENAGE PREGNANCY IN A FAMILY CONTEXT 124 (T.Ooms ed. (1981).

Furstenberg, another participant, reviewed the kinship roles of families in dealing with a problem pregnancy and strongly criticized pregnancy counseling for not involving parents and perhaps other interested relatives or parties in the decision. In his words, "if they are not consulted, or at least considered, the decision reached may be disruptive, unrealistic, or perhaps even destructive to the interests of both the adolescent and her family." Furstenberg, *Implicating the Family: Teenage Parenthood and Kinship Involvement*, TEENAGE PREGNANCY IN A FAMILY CONTEXT 162 (T.Ooms ed. 1981). And finally, T. Oooms, who was the deputy director of the Seminar and report editor, developed eight family impact principles based on the findings of the contributors, two of which are germane here:

> #3. Policies should recognize that an adolescent's pregnancy and childbearing can have profound effects on other members of her family, and that the family, therefore, has an interest in being consulted about the decisions she makes about her pregnancy.
>
> #6. Policies should reflect an understanding that

> families with adolescents are in a stage of transition in which parents' and children's roles and responsibilities undergo a process of negotiation and readjustment. Some disputes between them are to be expected as a natural part of this process. Furstenberg, *supra* at 373.

To exclude parental involvement from a daughter's pregnancy crisis is at best naive and at worst detrimental for future familial and interpersonal relationships. Parents are the primary reference group for most adolescents. J. CONGER, CONTEMPORARY ISSUES IN ADOLESCENT DEVELOPMENT (1975). Clinical and research evidence make it abundantly clear that the heritage of parent-child relationships that a young person carries into and through adolescence can have impact on how she feels about herself and others. Honing, *What We Need to Know to Help the Teenage Parent*, 27 FAM. COORDINATOR 113 (1978). In order for an adolescent to develop into a reasonably self-reliant, adaptable, creative and self-disciplined person there must be many opportunities to learn these patterns during the years of growing up.

Mothers in particular play a critical role in their daughter's sexuality. Mothers can be expected to influence their daughter's sex behavior indirectly through their presence and their availability in providing socioemotional support. Inazu and Fox, *Maternal Influence on the Sexual Behavior of Teen-age Daughters*, 1 J. FAM. ISSUES 81 (1980). Daughters whose socioemotional needs are met at home are less likely to become involved in intimate relationships outside the home to fulfill these needs. Evidence from numerous studies suggest non-virgins are more likely to have poorer communication with their mothers, Fox and Inazu, The Effects of Mother-Daughter Communication on Daughter's Sexual and Contraceptive Knowledge and Behavior (1979) (presented to Ann. Meeting of Population A. Am.); Chilman, *Some Psychological Aspects of Female Sexuality*, 23 FAM. COORDINATOR 123 (1974); Kantner and Zelnik, *Sexual Experiences of Young Unmarried Women in the United States*, 4 FAM. PLAN. PERSPECTIVES 9 (1972); to be lower on parental involvement, Miller and Simon, *Adolescent Sexual Behavior: Context and Change*, 22 Soc. Prob. 58 (1974); and to have less affectional relationships with their mothers, Jessor and Jessor, *Maternal Ieology and Adolescent Problem Behavior*, 10 Dev. Psych. 246 (1974). Teenage mothers are more prone to have daughters who themselves become teenage mothers. J. CARD, LONG-TERM CONSEQUENCES FOR CHILDREN BORN TO ADOLESCENT PARENTS (1978). Hence, the mother's role, be it positive or negative, is incontrovertible in her daughter's sexual development.

The multigenerational context of families is another key aspect which has received little attention in the abortion literature. The abortion decision interfaces directly with the developmental agenda of both daughters and mothers. Eriksonian developmental theory postulates adolescent growth spanning various stages: autonomy and separation, the establishment or consolidation of one's identity, the establishment of appropriate attachments to people outside the realm of the family, and self mastery over impulses including the ability to anticipate future consequences of present actions. Abortion subverts each of these stages in its over-emphasis on the individual and its separation from the relational context. It negatively impacts on self-identity mainly through guilt production, which is especially unnecessary and damaging at this stage of development. Abortion fosters pseudo trust and attachment with abortion personnel and aligns the individual with those who hold concurrent opinions. And lastly, abortion reinforces impulsivity, secrecy, and denial, increasing the probability of future dysfunctional problem solving.

The demanding roles of mothering and her developmental agenda interact concurrently with her daughter's stages of growth. The parent of a maturing daughter must serve as both protector of the daughter-as-child and as guide for the daughter-as-woman. *Fox*, *supra*, at 112-13. Abortion confounds these roles in that it can be a "silent solution" with no parental awareness or involvement, or the roles may be mistakenly interchanged. In addition, abortion impacts upon the mother's stages of development, i.e., the crisis of being (finding meaning beyond the maternal role), doing (accomplishment of re-entry into non-familial activities or responsibilities), and aging (coping with the loss of culturally valued youthfulness and beauty). Abortion not only voids motherhood, it also deifies "meism," and promotes insecurity via mother-daughter competitiveness.

A recent study of over four hundred mothers and their fourteen to sixteen year old daughters concluded:

> The mother's presence as a role model for her daughter, both in terms of her salience as a significant other in her daughter's life and in terms of her own non-martial sexual experiences, was significantly related to the daughter's sexual status...this study would suggest that policies which are directed at strengthening family functioning through undergirding adult family members in their roles as parents are as likely to be fruitful as policies targeted directly at teenagers. *Inazu and Fox, supra,* at 98-99.

This research, similar to the growing body of related studies, underscores the ultimate importance of the family unit as the primary context within which individual behavior is defined, developed, and differentiated.

And yet, how many teenagers involve their parents in their sexual decision making, including abortion. One study of fourteen hundred parents in Cleveland suggested most teenagers don't, E. ROBERTS, D. KLINE AND J. GAGNON, FAMILY LIFE AND SEXUAL LEARNING (1978); and on abortion, estimates vary from one out of five to maybe half who do. Rosen, *Adolescent Pregnancy Decision Making: Are Parents Important?*, 15 ADOLESCENCE 43 (1980).

In spite of fears raised as to parental condemnation, it should be realized that open and honest communication is a requisite for maturity and healthy personality development. Hence, it is not only expected that a problem pregnancy be disruptive of family dynamics, it is desirable, since it is away from this familial context that the minor daughter has turned, and where ultimately she must return and be accountable for her choice. On the other hand, it seems unfair to minimize the responsible concern of significant persons in a woman's life, or to act on the assumption that they are unconcerned or indifferent. Helping agents or family members who overlook relationship considerations in favor or unilateral prerogatives evade the basis human issues of mutuality and fairness, and injure the possibilities of future trusting relationships.

For those adolescents who involve their parents in abortion decision making, the initial emotional risks are high: fear of parental rejection, hurt, embarassment, loss of approval, and privileges. And yet, the potential for maturity, intimacy, and future familial and relational closeness is also high. For those who don't, there is a plethora of possible negative consequences: excessive guilt, intrapsychic conflict, alienation, self-rejection, damaged interactional abilities, increased fears, depression, loss of identity, and the likelihood of repeat abortions with their attendant physiological sequaelae.

To think then in terms of crisis decision making within the context of a relational vacuum is to program failure. Abortion as a crisis should be equivalently added to the list of other crises family members encounter, and need familial assistance in resolving: e.g., identity crises, rape, suicide, rejection, drug addiction, school problems, sibling hostility, phobias, death of a family member, emotional disturbances, etc. A successful resolution of the abortion crisis must come within the context of the family.

II

Requiring parental or court consent for an abortion on an immature unemancipated minor serves important state interests.

It is without dispute that "minors, as well as adults, are protected by the Constitution and possess constitutional rights," *Planned Parenthood v. Danforth*, 428 U.S. 52, 74 (1976), and these rights include those granted by *Roe v. Wade*. The inquiry on the constitutionality of restrictions on that right, however, does not end there. Sufficient state interests may support state imposed restrictions on that right. In the context of the requirement of parental or court consent for an immature unemancipated minor's abortion, there are substantial state interests which support a restriction in the minor's exercise of her abortion right.

There are at least three substantial state interests in requiring parental or court consent for an immature unemancipated minor's abortion: (1) the state's interest in fostering the family structure and preserving family autonomy, (2) the importance of the parental role, and (3) the state's interest in protecting minors against their own immaturity. By requiring parental consent or court consent, except in certain limited circumstances, these interests are advanced.

(1) The State's Interest in Fostering the Family Structure and Preserving Family Autonomy

The state has an important interest in maintaining the family structure. As fully delineated above, the family is the most appropriate and effective context in which to resolve a crisis of a family member, particularly minors. The resolution of this crisis within the family, while stressful at the time, serves the long-term well being of the minor. In only the most limited circumstances is it in the best interest of the minor to resolve a crisis without parental intervention.

This Court has long recognized the importance of the family and protected its autonomy. The integrity of the family unit has found protection in the Due Process Clause of the Fourteenth Amendment, *Meyer v. Nebraska*, 262 U.S. 390 (1923), the Equal Protection Clause of the Fourteenth Amendment, *Skinner v. Oklahoma*, 316 U.S. 535 (1942), and the Ninth Amendment. *Griswold v. Connecticut*, 381 U.S. 479 (1965). The protection of the family unit extends to family relationships unlegitimized by a marriage ceremony, *Levy v. Louisiana*, 391 U.S. 68 (1968), *Stanley v. Illinois*, 405 U.S. 645 (1972) and those consisting of relatives of several generations. *Moore v. City of East Cleveland*, 431 U.S. 494 (1977). The liberty interest in the family has its "source, and its contours... not in state law, but in intrinsic human rights, as they have been understood in 'this Nation's history and tradition'." *Moore v. City of East Cleveland, supra*, 431 U.S. at 503.

As one writer has stated:

> "The common law has long recognized parental rights as a key concept, not only for the specific purposes of domestic relations law, but as a fundamental cultural assumption about the family as a basic social, economic, and political unit. For this reason, both English and American judges view the origins of parental rights as being even more fundamental than property rights. Parental rights to custody and control of minor children have been variously described as 'sacred' as a matter of 'natural law,' and as 'inherent, natural right[s], for the protection of which, just as much as for the protection of the rights of the individual to life, liberty, and the pursuit of happiness, our government is formed.' *These judicial word choices imply that the parent-child relationship antedates the state in much the same sense as natural individual rights are thought to antedate the state in American political philosophy.* It has been said:

> Our political system is superimposed on and presupposes a social system of family units, not just of isolated individuals. No assumption more deeply underlies our society than the assumption that it is the individual [parent] who decides whether to raise a family, with whom to raise a family, and, in broad measure, what values and beliefs to inculcate in the children who will later exercise rights and responsibilities of citizens and heads of families. . . .
>
> . . .[T]he family unit does not simply coexist with our constitutional system; it is an integral part of it. In democratic theory as well as in practice, it is in the family that children are expected to learn the values and beliefs that democratic institutions later draw on to determine group directions. The immensely important power of deciding about matters of early socialization has been allocated to the family, not to the government." (Emphasis added.)

Hafen, *Children's Liberation and the New Equalitarianism: Some Reservations About Abandoning Youth to Their "Rights,"* 1976 BRIGHAM YOUNG U. L. REV. 604, 615-617.

(2) The Importance of the Parental Role

The rights of parents to the custody, care, and religious and moral education of their children is firmly established in the traditions and laws of the Nation. As concisely detailed by this Court:

> "[C]onstitutional interpretation has consistently recognized that the parents' claim to authority in their own household to direct the rearing of their children is basic to the structure of society. 'It is cardinal with us that the custody, care and nurture of the child reside first in the parents, whose primary function and freedom include preparation for obligations *the state can neither supply nor hinder*'." (Emphasis added.)

> *Ginsberg v. New York*, 390 U.S. 629, 639 (1968), quoting *Prince v. Massachusetts*, 321 U.S. 158, 166 (1944).

Parental interest can be of two types: (1) parents have a fundamental right to raise their children as they see fit and (2) parents have an interest in preserving their daughters' health and well being. The fundamental right of parents to educate and provide moral and other guidance to their children has long been honored by our law.

This Court in a series of cases dating from 1923 has recognized as fundamental these rights of parents under the Fourteenth Amendment. In *Meyer v. Nebraska, supra*, this Court held a Nebraska law making it a criminal offense to teach a foreign language to children before the ninth grade unconstitutional as a violation of the fundamental and "essential" rights of parents to control the education and upbringing of their children.

Similarly, *Pierce v. Society of Sisters*, 268 U.S. 510 (1925) held the same parental rights precluded the State from forbidding parents from sending their children to sectarian rather than public schools:

> The fundamental theory of liberty upon which all governments in this Union repose excludes any general power of the State to standardize its children by forcing them to accept instruction from public teachers only. The child is not the mere creature of the State; *those who nuture him and direct his destiny have the right, coupled with the high duty, to recognize and prepare him for additional obligations. Pierce*, 268 U.S. at 534-35. (Emphasis added.)

Parental interest in their children extends to their daughter's health and well being. Thus, the parent's right to supervise the upbringing and education of their children includes the "high duty" of parents "to seek and follow medical advise" and in so doing, will "act in the best interests of their children." *Parham v. J. R.*, 442 U.S. 584, 602 (1979). Thus, parents have an important interest in supplying essential medical and other information to a physician. This is true particularly with regards to abortion since its consequences can be "serious and...lasting," *H. L. v. Matheson*, 101 S.Ct. 1164, 1172 (1981), and are "markedly more severe in girls under 18 than in adults." *H. L. v. Matheson*, *supra*, 101 S.Ct. at 1172 n. 20.

The state, however, does have constitutional control over parental discretion in dealing with children when their physical or mental health is jeopardized. See *Wisconsin v. Yoder*, 406 U.S. 205, 230 (1972); *Prince v. Massachusetts*, *supra*, 321 U.S. at 166. The existence of child abuse and neglect laws attest to this occasional occurrence. This fact, however, "is hardly a reason to discard wholesale pages of human experience that teaches that parents generally do act in the child's best interests. (Citation omitted.) The statist notion that governmental power should supercede parental authority in *all* cases because *some* parents abuse and neglect children is repugnant to the American tradition." *Parham v. J. R.*, *supra*, 442 U.S. at 602.

These constitutional cases, therefore, clearly establish the following:

> (1) the ability of parents to raise their children has its source outside of government or positive law; (2) the parent-child relationship is a realm which is ordinarily outside the reach of the law; (3) the right of parents to raise their children as they see fit is constitutionally protected; and (4) the state can only interfere with parental control of their children in exceptional cases where necessary to protect the health or safety of the child or society. L.D. WARDLE, THE ABORTION PRIVACY DOCTRINE 172 (1980).

These authorities, therefore, make it clear that parents have a profound interest in raising their own children and controlling their conduct and that the state has a substantial interest in protecting those parental rights.

(3) The State Interest in Protecting Minors Against Their own Immaturity

The state has currently recognized the reduced capacity of minors to make mature and informed decisions and has, therefore, often acted to protect minors from their immaturity. In so doing, each state has established statutorily an age of majority and substantially limited the rights of minors for their own protection.

This Court has recognized this legitimate state interest. In *Bellotti v. Baird II*, 443 U.S. 622 (1979), Justice Powell carefully delineated three reasons why the constitutional rights of children cannot be equated with those of adults. *Bellotti v. Baird II, supra*, 443 U.S. at 634. Two of these reasons are included in the states interest in protecting minors against their own immaturity, i.e. the peculiar vulnerability of children and their inability to make critical decisions in an informed, mature manner. Thus, while minors are generally entitled to the same constitutional guarantees as adults, "the state is entitled to adjust its legal system to account for children's vulnerability and their need for 'concern...sympathy, and...parental attention.'" *Baird v. Bellotti II, supra*, 443 U.S. at 635, citing *McKeiver v. Pennsylvania*, 403 U.S. 528, 550 (1971). In addition, because minors do not possess the "full capacity for individual choice," *Ginsburg v. New York, supra*, 390 U.S. at 649 (Stewart, J. concurring), "the power of the states to control the conduct of children reaches beyond the scope of its authority over adults...." *Prince v. Massachusetts, supra*, 321 U.S. at 170. As a result, the state may prescribe conduct related to a minor which would be unconstitutional if directed toward an adult. *Ginsberg v. New York, supra*, 390 U.S. at 634. "Parents possess what a child lacks in maturity, experience, and capacity for judgment required for making life's difficult decisions." *Parham v. J.R., supra*, 442 U.S. at 602. The parents role, therefore, is often critical in preventing minors from being victimized by their own immaturity.

III

The requirement of parental or court consent for an immature, unemancipated minor is constitutional

The statute under review herein provides for parental or court consent for an abortion. Specifically, the statute prohibits an abortion to be performed upon a minor unless she has consented to the abortion and

(1) one parent has consented to the abortion,

(2) the minor is emancipated,

(3) the minor has been granted the right of self consent to the abortion by a court, or

(4) a court has consented to the abortion.

V.A.M.S. § 188.028.1. The statute then proceeds to delineate the procedures by which a court may grant the right of self consent to the minor or consent to the abortion itself. V.A.M.S. § 188.028.2.

The statute specifies the content of the petition to be filed by the minor which initiates the court proceedings. This petition, in part, should include that "the minor is of sound mind and has sufficient intellectual capacity to consent to the abortion" and "if the court does not grant the minor majority rights for the purpose of consenting to the abortion, the court should find that the abortion is in the best interests of the minor and give judicial consent to the abortion." V.A.M.S. § 188.028.2(1). Based upon the petition, the court is to hear evidence "relating to the emotional development, maturity and understanding of the minor. . . and any other evidence that the court may find useful in determining whether or not a minor should be granted majority rights for the purpose of consenting to the abortion or whether the abortion is in the best interests of the minor." V.A.M.S. § 188.028.2(3). Based upon the hearing, the court, for good cause, shall either "grant the petition for majority rights. . ., give judicial consent to the abortion. . . or deny the petition. . ." V.A.M.S. § 188.028.2(4).

The statute herein clearly contemplates that a court, in hearing the petition, shall determine whether or not a minor is sufficiently mature to give her own consent or, if not, whether or not the abortion is in the child's best interests. Only if the court finds neither of these facts may the court deny the abortion. See *Planned Parenthood v. Ashcroft*, 655 F.2d 848, 858 (8th Cir. 1981).

In its entire context, therefore, the statute favors parental consent to an abortion except under certain limited circumstances. i.e. when the child is emancipated, mature enough to make her own decisions,[3] and when an abortion is in the child's best interests. Unemancipated minors are within the care, custody and control of their parents. If the minor is immature, parental or court guidance regarding the best interests of the minor is clearly warranted. The statute provides for such third party review.

Decisions of this Court since *Roe v. Wade, supra*, have delineated the acceptable circumstances in which parental involvement in a minor's abortion decision is appropriate. In *Planned Parenthood v. Danforth, supra*, the Court held that a state may not impose a blanket parental veto on a minor's decision to have an abortion. This Court found that the *absolute* power of a parent to overrule a minor's decision to have an abortion would not serve to safeguard the family unit or parental authority. *Planned Parenthood v. Danforth, supra,* 428 U.S. at 75. "Any independent interest the parties may have in the termination of the minor daughter's pregnancy is no more weighty than the right of privacy of the competent minor mature enough to have become pregnant." Id.

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[3] "A mature minor is one who comprehends her condition, understands the options available, realizes the consequences associated with each alternative and who has developed basic skills of cognitive and moral judgments." WARDLE, *supra*, at 165. "There is no logical relationships between the capacity to become pregnant and the capacity for mature judgment concerning the wisdom of an abortion." *H. L. v. Matheson, supra*, 101 S.Ct. at 1170.

The companion case of *Baird v. Bellotti I,* 428 U.S. 132 (1976), makes clear that a state is not prohibited from requiring parental consent for immature, unemancipated minors where the abortion is not in her best interest. The *Baird* court found that:

> a statute that prefers parental consultation and consent, but that permits a mature minor capable of giving informed consent to obtain, without undue burden, an order permitting the abortion without parental consultation, and, further, permits even a minor incapable of giving informed consent to obtain an order without parental consultation where there is a showing that the abortion would be in her best interests...would be fundamentally different from a statute that creates a "parental veto."

Baird v. Bellotti I, supra, 428 U.S. at 145.

In *Baird v. Bellotti II, supra,* this Court was once again faced with the Massachusetts parental or court consent statute after an authoritative interpretation if by the Massachusetts Supreme Court. *Baird v. Attorney General,* 371 Mass. 741, 360 N.E.2d 288 (1977). The Massachusetts statute was again found wanting because it required parental notice of the judicial proceeding in which the right to self consent or judicial consent to the abortion is sought and because the statute did not permit court authorized self consent to the abortion for mature minors. *Baird v. Bellotti II, supra,* 443 U.S. at 647. (Powell, J. concurring). "Every minor who cannot secure the consent of both her parents...is required to secure the consent of the sovereign" and "the only standard provided for the judge's decree is the best interests of the minor." *Baird v. Belotti II*, *supra*, 443 U.S. at 655 (Stevens, J. concurring). A mature minor did not have the right of self consent.

The statute herein is fundamentally different than the Massachusetts statute in *Baird v. Bellotti II*. The Missouri statute allows a minor, who is sufficiently mature to make her own decisions, to give her own consent to the abortion. She need not obtain the consent of any third party, only a judicial determination of the fact that she is in fact sufficiently mature to make her own decisions. There is, therefore, no third party veto. In addition, by the striking of subsection V.A.M.S. § 188.028.2(2) requiring parental notice of the petition of the minor seeking judicial or self consent, the statute allows a minor to seek court review without parental knowledge. The defect in the Massachusetts statute requiring parental notice of the judicial proceeding is remedied.

The Missouri statute, therefore, serves important state interests identified previously. First, the statute supports family autonomy by supporting the authority of the parents within the family and recognizing the legitimacy of the family institution as it exists. By recognizing that an unemancipated minor is present within the family, the statute encourages family resolution of the crisis by requiring parental consent.

The Missouri statute also serves to protect parental rights and interests by encouraging parental consent. The statute supports the parent's privacy right to supervise the upbringing of their children. As stated by one commentator:

> "Parental authority, of course, means nothing if it does not mean the right to say no to a child. It also is worthless if the child does not have to get prior parental approval."

WARDLE, *supra*, at 176. This statute, except in limited circumstances, requires it.

Finally, the Missouri statute requiring parental or court consent protects immature minors against their own improvidence. Certainly no one is more prepared to make a decision about the capacity and maturity of a particular minor than her parents with whom she is living. In addition, a court may determine whether or not an abortion on the minor is in her best interest if she is too immature to make her own decision. Immature minors, therefore, must obtain consent from a mature third party who is acting in her best interest.

The Missouri statute is also narrowly drawn to effecuate these interests. While parental involvement in the abortion decision of an immature, unemancipated minor is favored, only when the abortion is in an immature minor's best interest may it be allowed by a court without parental involvement. Emancipated minors may give their own consent since they are then outside the sphere of parental authority and are no longer living with their family. Mature minors may consent to an abortion since the state's interest in protecting the minor from her own immaturity no longer exists. This statute, therefore, is narrowly tailored to meet the state interest involved.

Whether this Court is requiring a compelling interest, a significant interest or a rational interest to support a parental or court consent requirement for immature minors is not clear from the cases. In *Planned Parenthood v. Danforth, supra,* this Court examined whether there was any "significant state interest" which supported a parental veto of even a mature minor's decision to have an abortion. *Planned Parenthood v. Danforth, supra*, 428 U.S. at 75. In *Carey v. Population Services International*, 431 U.S. 678 (1977), this Court held that "inhibiting privacy rights of minors are valid only if they serve 'any significant state interest...that is not present in the case of an adult,'" *Carey v. Population Services International, supra*, 431 U.S. at 693, which is "apparently less rigorous than the 'compelling state interest' test applied to restrictions on the privacy rights of adults.Such lesser scrutiny is appropriate both because of the state's greater latitude to regulate the conduct of children...and (because) the law has generally regarded minors as having a lesser capability for making important decisions." *Carey v. Population Services International, supra*, 431 U.S. at 693 n. 15. In addition, *H. L. v. Matheson, supra*, described considerations of family integrity and protecting adolescents as "important" and the statute therein as serving "a significant state interest" of providing parents an opportunity to provide extensive medical and other information to the physician. On the other hand, the holding of *Roe v. Wade, supra*, that any intereference with the woman's abortion right must be supported by a compelling state interest is unreversed.

In either event, requiring parental or court consent for immature, unemancipated minors, while permitting a mature minor to give her own consent, obviously serves as important state interest, one that indeed may be characterized as compelling in this circumstance. Thus, in *Planned Parenthood v. Ashcroft, supra*, herein, the 8th Circuit, applying the compelling interest test, upheld the statute. In addition, in *Planned Parenthood v. Bellotti*, 641 F.2d 1006 (1st Cir. 1981), the First Circuit, applying the unduly burdensome test, also upheld a similar Massachusetts statute. Under either standard, the Missouri statute should be upheld.

CONCLUSION

The Missouri statute requiring parental or court consent for immature, unemancipated minors serves important state interests which are sufficient to restrict a minor's abortion privacy right. By allowing mature and emancipated minors to consent to an abortion, the statute is narrowly drawn to serve the important state interest involved. Accordingly, Amicus Curiae respectfully urge this Honorable Court to affirm the decision below.

Respectfully submitted,

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APPENDIX

V.A.M.S. § 188.028 provides as follows:

188.028. 1. No person shall knowingly perform an abortion upon a pregnant woman under the age of eighteen years unless:

(1) The attending physician has secured the informed written consent of the minor and one parent or guardian; or

(2) The minor is emancipated and the attending physician has received the informed written consent of the minor; or

(3) The minor has been granted the right to self-consent to the abortion by court order pursuant to subsection 2 of this section, and the attending physician has received the informed written consent of the minor; or

(4) The minor has been granted consent to the abortion by court order, and the court has given its informed written consent in accordance with subsection 2 of this section, and the minor is having the abortion willingly, in compliance with subsection 3 of this section.

2. The right of a minor to self-consent to an abortion under subdivision (3) of subsection 1 of this section or court consent under subdivision (4) of subsection 1 of this section may be granted by a court pursuant to the following procedures:

(1) The minor or next friend shall make an application to the juvenile court which shall assist the minor or next friend in preparing the petition and notices required pursuant to this section. The minor or the next friend of the minor shall thereafter file a petition setting forth the initials of the minor; the age of the minor; the names and addresses of each parent, guardian, or if the minor's parents are deceased and no guardian has been appointed, any other person standing in loco parentis of the minor; that the minor has been fully informed of the risks and consequences of the abortion; that the minor is of sound mind and has sufficient intellectual capacity to consent to

the abortion; that, if the court does not grant the minor majority rights for the purpose of consent to the abortion, the court should find that the abortion is in the best interest of the minor and give judicial consent to the abortion; that the court should appoint a guardian ad litem of the child; and if the minor does not have private counsel, that the court should appoint counsel. The petition shall be signed by the minor or the next friend;

(2) Copies of the petition and a notice of the date, time, and place of the hearing shall be personally served upon each parent, guardian or, if the minor's parents are deceased and no guardian has been appointed, any other person standing in local parentis of the minor listed in the petition by the sheriff or his deputy. If a parent or guardian or, if the minor's parents are deceased and no guardian has been appointed, any other person standing in loco parentis cannot be personally served within two days after reasonable effort, the sheriff or his deputy shall give constructive notice to them by certified mail to their last known address and the hearing shall not be held for at least forty-eight hours from the time of the mailing. In any case where there exists the potential or appearance of conflict of interests between the parents or guardian or next friend of the child and the child, the court shall appoint a guardian ad litem to defend the minor's interests. The court shall set forth, for the record, the grounds for such appointment;

(3) A hearing on the merits of the petition, to be held on the record, shall be held as soon as possible within five days of the filing of the petition. If any party is unable to afford counsel, the court shall appoint counsel at least twenty-four hours before the time of the hearing. At the hearing, the court shall hear evidence relating to the emotional development, maturity, intellect and understanding of the minor; the nature, possible consequences, and alternatives to the abortion; and any other evidence that the court may find useful in determining whether the minor should be granted majority rights for the purpose of consenting to the

abortion or whether the abortion is in the best interests of the minor;

(4) In the decree, the court shall for good cause:

(a) Grant the petition for majority rights for the purpose of consenting to the abortion; or

(b) Find the abortion to be in the best interests of the minor and give judicial consent to the abortion, setting forth the grounds for so finding; or

(c) Deny the petition, setting forth the grounds on which the petition is denied;

(5) If the petition is allowed, the informed consent of the minor, pursuant to a court grant of majority rights, or the judicial consent, shall bar an action by the parents or guardian of the minor on the grounds of battery of the minor by those performing the abortion. The immunity granted shall only extend to the performance of the abortion in accordance herewith and any necessary accompanying services which are performed in a competent manner. The costs of the action shall be borne by the parties.

(6) An appeal from an order issued under the provisions of this section may be taken to the court of appeals of this state by the minor or by a parent or guardian of the minor. The notice of intent to appeal shall be given within twenty-four hours from the date of issuance of the order. The record on appeal shall be completed and the appeal shall be perfected within five days from the filing of notice to appeal. Because time may be of the essence regarding the performance of the abortion, the supreme court of this state shall, by court rule, provide for expedited appellate review of cases appealed under this section.

3. If a minor desires an abortion, then she shall be orally informed of and, if possible, sign the written consent required by section 188.039 in the same manner as an adult person. No abortion shall be performed on any minor

against her will, except than an abortion may be performed against the will of a minor pursuant to a court order described in subdivision (4) of subsection 1 of this section that the abortion is necessary to preserve the life of the minor.

Amicus Brief

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Nos. 81-1255 and 81-1623

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IN THE

Supreme Court of the United States

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PLANNED PARENTHOOD ASSOCIATION OF KANSAS CITY, MISSOURI, INC., NAIM S. KASSAR, M.D., REPRODUCTIVE HEALTH SERVICES and ALLEN S. PALMER, D.O.,

Petitioners and Cross-Respondents,

—vs.—

JOHN ASHCROFT, ATTORNEY GENERAL OF THE STATE OF MISSOURI, and RALPH L. MARTIN, PROSECUTING ATTORNEY OF JACKSON COUNTY, MISSOURI,

Cross-Petitioners and Respondents.

ON A WRIT OF CERTIORARI TO THE UNITED STATES
COURT OF APPEALS FOR THE EIGHTH CIRCUIT

BRIEF OF AMICI CURIAE PLANNED PARENTHOOD FEDERATION OF AMERICA, INC., NATIONAL FAMILY PLANNING AND REPRODUCTIVE HEALTH ASSOCIATION, INC., ASSOCIATION OF PLANNED PARENTHOOD PHYSICIANS, INC., SOCIETY FOR ADOLESCENT MEDICINE, THE AMERICAN JEWISH CONGRESS, THE AMERICAN PSYCHIATRIC ASSOCIATION, THE AMERICAN ASSOCIATION OF SEX EDUCATORS, COUNSELORS AND THERAPISTS AND CERTAIN MEDICAL SCHOOL DEANS AND PROFESSORS IN SUPPORT OF PETITIONERS AND CROSS-RESPONDENTS

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Nos. 81-1255 and 81-1623

IN THE

SUPREME COURT OF THE UNITED STATES

October Term, 1982

PLANNED PARENTHOOD ASSOCIATION OF KANSAS CITY,
MISSOURI, INC., NAIM S. KASSAR, M.D., REPRODUCTIVE
HEALTH SERVICES AND ALLEN S. PALMER, D.O.,

Petitioners and Cross-Respondents,

vs.

JOHN ASHCROFT, ATTORNEY GENERAL OF THE STATE
OF MISSOURI, AND RALPH L. MARTIN, PROSECUTING ATTORNEY
OF JACKSON COUNTY, MISSOURI,

Cross-Petitioners and Respondents,

On A Writ Of Certiorari To The United States
Court of Appeals For The Eighth Circuit

BRIEF OF AMICI CURIAE PLANNED PARENTHOOD FEDERATION OF AMERICA, INC., NATIONAL FAMILY PLANNING AND REPRODUCTIVE HEALTH ASSOCIATION, INC., ASSOCIATION OF PLANNED PARENTHOOD PHYSICIANS, INC., SOCIETY FOR ADOLESCENT MEDICINE, THE AMERICAN JEWISH CONGRESS, THE AMERICAN PSYCHIATRIC ASSOCIATION, THE AMERICAN ASSOCIATION OF SEX EDUCATORS, COUNSELORS AND THERAPISTS AND CERTAIN MEDICAL SCHOOL DEANS AND PROFESSORS IN SUPPORT OF PETITIONERS AND CROSS-RESPONDENTS

BRIEF OF AMICI CURIAE PLANNED PARENTHOOD FEDERATION OF AMERICA, INC., NATIONAL FAMILY PLANNING AND REPRODUCTIVE HEALTH ASSOCIATION, INC., ASSOCIATION OF PLANNED PARENTHOOD PHYSICIANS, INC., SOCIETY FOR ADOLESCENT MEDICINE, THE AMERICAN JEWISH CONGRESS, THE AMERICAN PSYCHIATRIC ASSOCIATION, THE AMERICAN ASSOCIATION OF SEX EDUCATORS, COUNSELORS AND THERAPISTS AND CERTAIN MEDICAL SCHOOL DEANS AND PROFESSORS IN SUPPORT OF PETITIONERS AND CROSS-RESPONDENTS

Planned Parenthood Federation of America, Inc., National Family Planning and Reproductive Health Association, Inc., Association of Planned Parenthood Physicians, Inc., Society for Adolescent Medicine, the American Jewish Congress, the American Psychiatric Association, the American Association of Sex Educators, Counselors and Therapists and certain Medical School Deans and Professors respectfully submit this brief as _amici curiae_ in support of petitioners and cross-respondents. All parties have given their consent for the filing of this brief in letters filed with the Clerk of this Court.

INTEREST OF AMICI

Planned Parenthood Federation of America, Inc.

Planned Parenthood Federation of America, Inc., also known as Planned Parenthood-World Population

(Planned Parenthood), is a not-for-profit corporation organized in 1922 and existing under the laws of the State of New York. Its headquarters are in New York City. It is the leading national voluntary public health organization in the field of family planning.

Planned Parenthood has 190 affiliates in forty-three states and the District of Columbia. Each affiliate is a separate and autonomous not-for-profit corporation exempt from taxation under Section 501(c)(3) of the Internal Revenue Code. These affiliates operate approximately 691 family planning clinics offering services to the public. Most affiliates offer medical services including thirty-seven which offer abortion services as part of their program. Four affiliates are educational units without medical services. Most Planned Parenthood affiliates which do not perform abortions themselves offer pregnancy counseling and referral.

Planned Parenthood provides its affiliates with guidance in the areas of contraception, voluntary sterilization, infertility, abortion, sex education and education for marriage and parenthood. Each of the affiliates offering medical services functions under strict medical standards promulgated by Planned Parenthood's National Medical Committee in conjunction with local medical committees. The National Medical Committee consists of leading experts in the fields of obstetrics and gynecology, epidemiology, pharmacology, oncology, and public health. Local committees are made up of health professionals, the large majority of whom are physicians.

The National Medical Committee has approved the provision of abortions through the eighteenth week of pregnancy by the dilatation and evacuation (D & E) method at selected affiliate freestanding clinics. Planned Parenthood provides these relatively low-cost and safe procedures as part of its commitment to the principle that safe abortions should be available to all who seek them. While Planned Parenthood does not view abortion as an alternative to contraception, it recognizes that abortion services are essential to protect women when contraception is unavailable, when it has not been used for some other reason and when it has failed. Planned Parenthood opposes Missouri's requirement that abortions after the twelfth week of pregnancy be performed in hospitals (Mo. Rev. Stat. §188.025) because it places an unjustifiable obstacle in the path of women in need of safe, legal mid-trimester abortions.

Planned Parenthood has a long-standing commitment to making its services available to young people. This commitment arises out of a concern for individual rights and a recognition of the damaging consequences that unwanted pregnancy can have for a teenager's health and the achievement of her life's goals. While Planned Parenthood believes that young women will generally benefit from the advice and support of their parents when attempting to resolve a problem pregnancy, it recognizes that this is not always possible. Although Planned Parenthood encourages parental involvement, it does not believe that care should be withheld in circumstances where young women are unable or unwilling to consult their parents or where parents withhold consent. The organization believes that minors should be permitted to make the decision whether or not to have an abortion and whether or not to involve their families free of state interference. Where the state has intervened, however, the procedures for a judicial alternative to parental involvement must not be burdensome and must allow the mature minor to make an independent decision. Planned Parenthood believes the Missouri statute has failed to meet these standards.

National Family Planning and Reproductive Health Association, Inc.

The National Family Planning and Reproductive Health Association, Inc. (NFPRHA) is a national private non-profit membership organization headquartered in Washington, D.C. devoted to the improvement and expansion of the delivery of family planning and reproductive health care services throughout the

United States. With over 1300 members, it is the largest organization in the nation composed of providers and consumers of family planning and reproductive health care services. NFPRHA's members -- which include Planned Parenthood affiliates, independent private non-profit umbrella family planning councils and individual family planning clinics, hospitals, and state, county and local agencies -- are committed to establishing and maintaining reproductive health care as a high priority preventive health care service in this country.

Association of Planned Parenthood Physicians, Inc.

Planned Parenthood works closely with the Association of Planned Parenthood Physicians, Inc. (APPP), a New York not-for-profit corporation organized in 1974. APPP is the successor to the American Association of Planned Parenthood Physicians, an unincorporated association which was organized in 1963. APPP has 670 members, all of whom are physicians or health professionals associated with family planning.

APPP was formed for scientific, educational and charitable purposes and specifically to promote the ongoing interest in family planning in order to improve the stability and health of the family through responsible parenthood.

Society for Adolescent Medicine

The Society for Adolescent Medicine is a national organization of health care providers to the adolescent age population. It consists of 900 active members all of whom are physicians and other health professionals.

The American Jewish Congress

The American Jewish Congress, a national organization of American Jews, was founded to protect the fundamental freedom of Jews and all Americans. The American Jewish Congress neither favors nor opposes abortion but believes that a woman's decision whether to undergo abortion must be her own, uncoerced by government.

The American Psychiatric Association

The American Psychiatric Association is the nation's largest organization of physicians who specialize in the practice and study of psychiatry; approximately 27,000 of the nation's 34,000 psychiatrists are members. The Association has long had a policy favoring medically appropriate abortions, because the opportunity to obtain such abortions implicates major psychiatric concerns. The issues raised by this case directly relate to the policies of the Association.

American Association of Sex Educators, Counselors and Therapists

The American Association of Sex Educators, Counselors and Therapists is a national non-profit membership organization founded in 1967. Its aims are to assist those professionals responsible for sex education, counseling and therapy programs by providing standards of competency in these areas.

Individual Professors and Medical School Deans

The individual physicians who as amici subscribe to this brief all practice obstetrics and gynecology as their medical specialty or are responsible for the education of medical students and residents, some of whom are in training in the specialty of obstetrics and gynecology.

Amici submit this brief in order to demonstrate for the Court the impact of the Missouri statute on the health of pregnant women.

SUMMARY OF ARGUMENT

Amici submit this brief to urge affirmance of the Court of Appeals holding that Mo.Rev.Stat. 188.025, requiring that all post-first trimester abortions be performed in hospitals, is unconstitutional. *Amici* urge reversal of the Court of Appeals holding that Mo.Rev.Stat 188.028, requiring parental or judicial consent to minors' abortions, is constitutional.

Amici argue that the requirement that all post-first trimester abortions be performed in hospitals is unconstitutional because it does not reasonably relate to the preservation of maternal health. Following the reasoning of the Court of Appeals, *amici* first demonstrate that the D & E technique is the safest and most commonly used of mid-trimester abortion techniques; second, that the hospitalization requirement significantly interferes with women's ability to obtain these abortions and therefore, must be strictly scrutinized to determine if it reasonably relates to protecting health. Finally, *amici* argue that the hospitalization requirement does not protect health because D & E abortions are performed with at least the same degree of safety in freestanding clinics as in hospitals.

In regard to the requirement of parental or judicial consent to minors' abortions, amici argue that the statute unduly burdens minors' right to choose abortion. First, the statute fails to allow a mature minor to make an abortion decision independently second, the statute fails to provide the confidential and expeditious judicial alternative which is constitutionally required when a state legislates to encourage parental involvement in a minor's abortion decision.

ARGUMENT

I. MISSOURI'S REQUIREMENT THAT ALL POST-FIRST TRIMESTER ABORTIONS BE PERFORMED IN HOSPITALS IS UNCONSTITUTIONAL BECAUSE IT IS NOT A REASONABLE MEANS OF PROTECTING MATERNAL HEALTH

In Roe v. Wade, 410 U.S. 113, 155 (1973), this Court held that the right to obtain an abortion is a fundamental constitutional right which may be curtailed only by legislation narrowly tailored to advance compelling state interests. Protecting the woman's health, this Court said, becomes such a compelling interest at the end of the first trimester of pregnancy. Id. at 163.

> This is because of the now-established medical fact...that until the end of the first trimester mortality in abortion may be less than mortality in normal childbirth. It follows that, from and after this point, the State may regulate the abortion procedure to the extent that the regulation reasonably relates to the preservation of maternal health. Examples of permissible state regulation in this area are requirements...as to the facility in which the procedure is to be performed, that is, whether it must be in a hospital or may be in a clinic or some other place of less-than-hospital status...

Id. (emphasis added).

Advances in medical science since the Roe decision have led to increased safety for abortions after the first trimester. When performed early in the second trimester by the dilatation and evacuation (D & E) method, a method not generally available in 1973, abortion is far safer than childbirth. Significantly, performing these abortions in hospitals does not enhance their safety. A substantial track record of good medical care and low morbidity and mortality has been achieved by non-hospital facilities which now perform the majority of midtrimester D & E procedures in this country. Recognizing this record, major health organizations, including Planned Parenthood Federation of America, the American Public Health Association and the American College of Obstetricians and Gynecologists have now endorsed the provision of abortions in freestanding clinics through the eighteenth week of gestation.*

Based on these data, to be more fully set forth in the argument which follows, amici urge this Court to reconsider the foregoing dicta from Roe v. Wade and to hold that confining all post-first trimester abortions to hospitals is no longer a reasonable means of furthering the states' compelling interest in women's health.

Following the reasoning of the Court of Appeals, amici will first demonstrate that the D & E technique is the safest and most commonly used of midtrimester abortion techniques; second, that the hospitalization requirement significantly interferes with women's ability to obtain D & E abortions and, therefore, must be strictly scrutinized to determine if it reasonably relates to protecting health. Finally, amici will argue that the hospitalization requirement does not protect health because D & E abortions are performed with at least the same degree of safety in free-standing clinics as in hospitals. See, Planned Parenthood Association of Kansas City v. Ashcroft, 655 F.2d 848 (8th Cir. 1981) and 664 F.2d 687 (8th Cir. 1981) (supplemental opinion).

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*Throughout this brief "gestational age" refers to weeks since the first day of the pregnant woman's last menstrual period.

A. Abortion By The Dilatation And Evacuation Method Is The Most Commonly Used And Safest Of Mid-Trimester Abortion Techniques

There are three basic medical techniques for performing second trimester abortions. The first, and most commonly used, is to gradually dilate the woman's cervix, the opening to the uterus, and remove the products of conception vaginally by means of suction and instruments. This technique is known as "dilatation and evacuation" (D & E). A second method is to induce labor and expulsion of uterine contents, most commonly by intrauterine instillation of saline solution or prostaglandins. The third method, now rarely used because of its high risk, is hysterotomy, which involves making a surgical incision through the abdominal wall and uterus and manually removing uterine contents.[1/]

In 1973, when Roe v. Wade was decided, dilatation of the cervix and vaginal removal of uterine contents was used to perform first trimester abortions, but it was believed unsafe to use similar techniques past the twelfth week of gestation. Women seeking abortions after this point were therefore usually given instillation procedures. Moreover, because the uterus is not generally of sufficient size to perform this procedure until after the sixteenth week of pregnancy, a delay of a month or more existed between the close of the first trimester and the time when a woman could safely receive an abortion.[2/] Because abortion becomes more dangerous as pregnancy advances and because instillation procedures are generally more

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[1/] Grimes & Cates, Dilatation and Evacuation, in Second Trimester Abortion: Perspectives After a Decade of Experience 119-20 (Berger, Brenner & Keith eds. 1981)(hereinafter cited respectively as "Dilatation and Evacuation" and "Second Trimester Abortion").

[2/] Cates, D & E after 12 weeks: safe or hazardous?, 13 Contemporary Ob/Gyn 23 (1979) dangerous than those performed by vaginal removal of uterine contents,[3/] this Court's 1973 conclusion that after the first trimester of pregnancy, abortion is as dangerous as or more dangerous than childbirth rested at that time on a firm scientific foundation.

Since 1973 physicians have found that they can safely use dilatation and evacuation methods past the twelfth week of pregnancy. The cervix is dilated to a somewhat wider diameter, often by means of laminaria, a dried plant which expands on contact with moisture and which is introduced into the cervix a day or several hours before the abortion. In addition to the endometrial aspiration of first trimester abortions, a curette and forceps are used to remove uterine

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[3/] *See generally*, Cates, *et al.*, *The Effect of Delay and Method Choice on the Risk of Abortion Morbidity*, 9 Family Planning Perspectives 266 (1977) and Cates & Grimes, *Morbidity and Mortality in Second Trimester Abortion*, *supra* note 1 at 163-78.

contents.[4/]

The availability of the D & E technique in the 13 to 15 week interval, the former "grey area" when it was thought no abortion could be performed safely, has substantially increased the safety of second trimester abortions. More and more of the abortions formerly delayed beyond the sixteenth week and consigned to instillation procedures are being performed earlier in pregnancy by this inherently safer method. Consequently, the death to case rate for all second trimester abortions in this country has fallen precipitously from 14.4 deaths per 100,000 abortions in 1972 to 7.6 per 100,000 in 1977.[5/] One authority believes that if D & E were made even more widely available 80% of abortions now performed at seventeen weeks of gestation or later

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[4/] Dilatation and Evacuation, supra note 1 at 121-28.

[5/] Tyler, et al., Second Trimester Induced Abortion in the United States, in Second Trimester Abortion, supra note 1 at 17-20.

would be performed earlier and mortality and morbidity rates would drop even further.[6]

By 1978 D & E procedures accounted for 51% of all second trimester abortions and 82.1% of abortions performed at 13 to 15 weeks gestation.[7] Every study has shown this method to be the safest for terminating post-first trimester abortions and far safer than childbirth. 1978 figures compiled by the U. S. Centers for Disease Control show abortion by the D & E method to have an overall mortality rate of 7.7 deaths per 100,000 abortions performed, as compared to instillation methods which have a mortality rate of 12.3 deaths per 100,000 abortions.[8] When performed at 13-15 weeks, a time when instillation is generally not possible, D & E

6/ Cates, D & E after 12 weeks: safe or hazardous?, supra note 2 at 28.

7/ Centers for Disease Control, U.S. Dept. of H.H.S. Abortion Surveillance 1978 at Table 14 (1980); (hereinafter cited as "Abortion Surveillance")' Cates & Grimes, Deaths from Second Trimester Abortion by Dilatation & Evacuation: Causes, Prevention and Facilities, 58 Obstetrics and Gynecology 401 (1981).

8/ Abortion Surveillance, supra note 7 at Table 23.

death rates are only 5.6 per 100,000 abortions.[9/] Significantly, the majority of D & E procedures were performed in a non-hospital setting.[10/] These mortality rates compare favorably with those of childbirth which 1978 statistics show to be 9.6 deaths per 100,000 births.[11/]

Studies of morbidity have also borne out the comparative safety of the D & E method. For example, a 1977 study conducted by the Joint Program for the Study of Abortion, now under the auspices of the U.S. Centers for Disease Control, compared mid-trimester D & E's to saline instillation abortions. The study found the relative risk of sustaining one or more major complications was 2.6 times higher for saline than for D & E's even after adjusting for such factors as gestational age, patient age and

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[9/] Id.

[10/] Deposition of Dr. Willard Cates, p. 10 in Joint Appendix, p. 46.

[11/] U. S. Dept. of Commerce, Bureau of the Census, Statistical Abstract of the United States: 1980 Table 114 (101st ed. 1980).

level of operator training.[12/] A study sponsored by the University of North Carolina compared D & E abortions with prostaglandin instillations performed by the same physician and found lower rates of total complications for women who underwent D & E's.[13/] Other comparative studies have shown similar results.[14/]

The superior safety record of the D & E method results from a number of factors. As previously stated it has eliminated the "grey area" from thirteen to fifteen weeks when it was previously thought no abortion could be safely performed and thus minimized the overall health risks which rise as pregnancy advances.[15/] The method is also

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[12/] Cates & Grimes, Morbidity & Mortality in Second Trimester Abortion, *supra* note 1 at 168.

[13/] *Id.*

[14/] *Id.* at 166-69. *See also*, Dilatation and Evacuation, *supra* note 1 at 123-26.

[15/] Note 3 *supra*.

inherently safer than inducing labor by intrauterine instillation of abortifacients. The D & E technique, entailing vaginal evacuation of uterine contents using surgical instruments, is direct and rapid and avoids the "uncertain induction of prolonged labor and the systemic side effects of the two instillation methods."[16/] The D & E method is also significantly less psychologically stressful for the woman than instillation procedures. In the latter the woman must undergo frequently painful labor over several days until uterine contents are expelled; in the former, the woman is given local or general anesthesia for a twenty

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16/ Grimes, et al., Methods of Midtrimester Abortion: Which is Safest?, 15 Int'l J. Gynaecol. Obstet. 184, 187 (1977)

As one authority explains, the human uterus has evolved the capacity to firmly retain its contents in the second trimester, so that induction of labor at that point in pregnancy is "slow, unpredictable and painful." Dilatation and Evacuation, supra note 1 at 119-20.

minute procedure.[17/]

In conclusion, dilatation and evacuation is the most commonly used and the safest of mid-trimester abortion techniques. _Accord_, _Planned Parenthood of Kansas City, Mo. v. Ashcroft_, 655 F.2d 848, 855 (8th Cir. 1981); _Margaret S. v. Edwards_, 488 F.Supp. 181, 193 (E.D. La. 1980); _Wolfe v. Stumbo_ C80-02859L (A), slip. op. at 2 (W.D. Ky. Dec 3, 1980); _Livingston v. N.J. Board of Medical Examiners_, 168 N.J. Super 259 (App. Div. 1979), _certif_. _den'd_ 82 N.J. 291 (1979); _Akron Center for Reproductive Health v. City of Akron_, 651 F.2d 1198, 1209 (6th Cir. 1981).

B. The Post-First Trimester Hospitalization Requirement Creates Substantial Interference With And Imposes A Direct Burden On A Woman's Abortion Decision, And, Therefore, Triggers Strict Scrutiny

Convinced that D & E is the safest method of

[17/] _Dilatation and Evacuation_, _supra_ note 1 at 130-31. _See also_ Rooks & Cates, _Emotional Impact of D & E v. Instillation_, 9 Family Planning Perspectives 276 (1977).

mid-trimester abortion, the Eighth Circuit went on to examine the effect on Missouri women of requiring that these procedures be performed in hospitals. Finding that the hospitalization requirement created a "substantial interference with and imposed a direct burden on a woman's abortion decision," the Court applied strict judicial scrutiny to determine whether the requirement was reasonably related to maternal health. 664 F.2d at 689.

The factual findings which triggered strict scrutiny for the court below were (1) only one hospital in the state performs D & E procedures; (2) hospitalization can double the cost of the abortion, thereby placing a financial burden on women seeking abortions; and (3) a hospitalization requirement results in fewer second trimester abortions being performed in Missouri than if there were no such requirement. Id. at 688.

The Missouri situation is not unique. Every court which has examined the issue has found that a hospitalization requirement had a drastic effect on the availability of second trimester abortions. See e.g., Louisiana, Margaret S. v. Edwards, 488 F. Supp. 181, 192 (E.D. La. 1980) (no abortions after the first trimester performed in Louisiana hospitals); Kentucky, Wolfe v. Stumbo, C80-02859L (A) (W.D. Ky. Dec 3, 1980) slip op at 2, (no elective post-first trimester abortion performed in Kentucky hospitals). Ohio, Akron Center for Reproductive Health v. City of Akron, 651 F.2d 1198, 1208 (6th Cir. 1981) (only two hospitals in the City of Akron performed a total of nine second trimester abortions in a year).

National figures bear out the general unwillingness of hospitals to provide abortion services and the particular difficulty of obtaining a second trimester abortion in a hospital.

In 1980, only 27% of short-term general non-Catholic hospitals performed any abortions and about one-third of these performed fewer than thirty abortions per year. Although many poor women rely on public hospitals for health care, only 17% of these institutions, as compared with 34% of private facilities, offer any abortion services. Moreover, the bulk of hospital abortion facilities are concentrated in metropolitan areas. Only 13% of non-Catholic hospitals in non-metropolitan areas provide any abortion services.[18/]

Only 37% of hospital abortion providers offer abortions past the twelfth week of gestation; past the fourteenth week, abortions are available in only 32% of such facilities. Thus, of all non-Catholic general hospitals, about one in 10 offer any second trimester abortions. Virtually all of these providers are in metropolitan areas.[19/]

[18/] Henshaw, et al., Abortion Services in the United States, 1979 and 1980, 14 Family Planning Perspectives 5, 11-12 (1982).

[19/] Id. at Table 12 and Henshaw, et al., Abortion in the United States, 1978-79, 13 Family Planning Perspectives 6, 17 (1981).

The result is a greater unmet need for these services in states where hospitalization is required in the second trimester than in those where it is not. The proportion of abortions past twelve weeks of gestation is 33% lower on the average, in the states with hospitalization requirements than in the states without them. This suggests that in the average state with restrictions, 33% of the women who might be expected to need mid-trimester abortions are either not obtaining them or are traveling to other states for these services.[20/] Travel adds to the cost of the

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[20/] Tabulations compiled from Centers for Disease Control, U.S. Dept. of H.H.S. Abortion Surveillance 1978 at Table 12 (1980). Twelve states with hospitalization requirements were sampled and compared to twenty-four states without requirements. Statistical analysis compiled by the Alan Guttmacher Institute, New York, New York.

procedure but also adds to the delay[21/] and any delay heightens the health risks for the woman.[22/]

Hospitalization also, of course, increases the cost of the procedure. In 1978, the average clinic charged $284 for a D & E abortion while the average hospital charge, in the few hospitals that provided such procedures, was $435. The hospital charge did

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[21/] Because of the scarcity of mid-trimester abortion providers generally, women have to leave their home states more often for these procedures than for those received earlier in pregnancy. In a representative sample of eight states, 21% of women obtaining abortions past fourteen weeks gestation did so outside their state of residence, as compared to 10% of women obtaining abortions at twelve weeks or earlier. Statistical tabulation compiled by the Alan Guttmacher Institute from 1978 data from the National Center for Health Statistics (computer tape). The hospitalization requirement only exacerbates these conditions by depleting the number of available abortion providers.

[22/] Note 3, supra and sources cited therein.

not include the physician's fee which ran as high as $300.[23] These added costs of hospitalization, including the added cost of travel, have a particularly disastrous impact on poor women, since only a small minority of the states cover the cost of even medically necessary abortions under their Medicaid programs.[24] Although no data are available to correlate income level with frequency of mid-trimester abortions, data on educational level indicate that women with an eighth grade education or less are three times as likely as college graduates to have their abortions after the twelfth week of gestation.[25]

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[23] Rosoff, The Availability of Second Trimester Abortion Services in the United States, in Second Trimester Abortion, *supra* note 1 at 35.

[24] The federal government reimburses the states only for abortions needed to preserve life. P.L. 97-161 (1982) (The Hyde Amendment). Nine states (Alaska, Colorado, Hawaii, Maryland, Michigan, New York, North Carolina, Oregon and Washington) and the District of Columbia voluntarily pay for abortions under their Medicaid programs and five states (California, Connecticut, Massachusetts, New Jersey and Pennsylvania) fund abortions under state court orders.

[25] Statistical tabulation compiled by the Alan Guttmacher Institute, New York, N.Y. from 1978 computer data tape supplied by the National Center for Health Statistics.

These difficulties are heightened for young women under eighteen, who receive a disproportionately high number of mid-trimester abortions.[26/] In addition to the financial barrier and increased health risks, they face the absolute barrier of having to obtain parental permission for their abortions more frequently in hospitals than in clinics.[27/]

These burdens of difficulty of access, increased cost, delay and added health risks are, as the Court of Appeals found, substantial interferences

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26/ Twenty-three percent of women less than fifteen years old receive their abortions past twelve weeks gestation; thirteen percent of fifteen to nineteen year olds receive abortion at that stage of pregnancy as compared to 8.5% of twenty to twenty-four year olds. Centers for Disease Control U.S. Dept of H.H.S., Abortion Surveillance 1978 at Table 15 (1979).

27/ Torres, *et al.*, *Telling Parents: Clinic Policies and Adolescents' Use of Family Planning and Abortion Services*, 12 Family Planning Perspectives 284, 286 (1980). See also *Planned Parenthood of Kansas City, Mo. v. Ashcroft*, 483 Supp. 679, 687 (W.D. Mo. 1980) (no hospital in Missouri admits women under eighteen without parental consent).

with a woman's ability to exercise her constitutional right to abortion. Moreover, the burden is directly imposed by the state and therefore requires strict judicial scrutiny. 664 F.2d at 689.

This case is plainly distinguishable from Harris v. McRae, 448 U.S. 297 (1980) in which this Court upheld the government's refusal to pay for abortions under the federal Medicaid Program. In Harris, this Court found poor women's inability to obtain abortions was not a result of direct state interference but the woman's own indigency. 448 U.S. at 316. In contrast, in the instant case, the state has directly prohibited a woman from receiving an abortion she wishes to obtain at her own expense from her own physician. Because of the state's direct intervention in preventing these procedures women must incur added expense and travel long distances; in some cases these burdens will be insurmountable and the woman will be unable to obtain an abortion which, absent the state's intervention, would have been readily available to her. The increased costs and decreased accessibility resulting from direct state regulation have long been held to trigger strict scrutiny in cases dealing with the constitutional right to privacy.[28]

C. Post-First Trimester Abortions May Be Performed Safely In Non-Hospital Facilities

Applying strict scrutiny, the Court of Appeals found that requiring all post-first trimester abortions to be performed in hospitals did not reasonably relate to furthering the state's interest in protecting women's health. Specifically, the Court found that the state had not carried its burden of establishing that abortions by the D & E method are more safely performed in hospitals than in clinics. 664 F.2d at 689-90.

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[28] See e.g., Carey v. Population Services Int'l 431 U.S. 678, 689 (1977); Doe v. Bolton, 410 U.S. 179, 193-95 (1973). In Carey this Court applied strict scrutiny to a statute that restricted sales of contraceptives to pharmacies. This Court noted the restriction "renders contraceptive devices considerably less accessible to the public, reduces the opportunity for privacy of selection and purchase and lessens the possibility of price competition." Id. Similarly, in Doe, this court struck down Georgia's requirement that all abortions be performed in hospitals because the state failed to show the restriction advanced maternal health in the first trimester. Id.

About two-thirds of D & E abortions past the twelfth week of gestation are currently being performed in non-hospital facilities.[29] As stated previously, D & E is the safest method of second trimester abortion. Medical evidence indicates that the high degree of comparative safety associated with this procedure exists in both clinics and hospitals.[30] A recent study of the eighteen deaths resulting from D & E abortions in the seven year interval between 1972 and 1978 revealed no higher incidence of deaths in nonhospital than hospital facilities.[31/] This and other data led the authors to recommend general abandonment of a hospitalization requirement for D & E procedures through the sixteenth week of pregnancy with the gestational limit to be slowly advanced as operator techniques improve.[32/]

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[29] Deposition of Dr. Willard Cates, p. 10 in Joint Appendix, p. 46 (hereinafter cited as "J.A.")

[30] Dilatation and Evacuation, *supra* note 1 at 121 and studies cited therein.

A number of experts have opined that non-hospital D & E abortions may in fact be safer than similar procedures in hospitals. One factor leading to this conclusion is that operator skill rather than operative setting is a major factor in assuring safety in D & E abortions.[33/]

[31/] Cates & Grimes, Deaths from Second Trimester Abortion by Dilatation and Evacuation: Causes, Prevention, Facilities, 58 Obstetrics and Gynecology 401 (1981). The authors, in fact, found that hospitals had a higher mortality rate but felt this finding should be viewed with caution in light of the low numbers involved and the fact that women with more serious medical conditions are often referred to hospitals. *Id.* at 406.

[32/] *Id.* at 407. The authors were at the time of writing the article, Chief and Assistant Chief of the Abortion Surveillance Branch, Family Planning Evaluation Division, Centers for Disease Control (U.S. Department of Health and Human Services).

[33/] Deposition of Dr. Willard Cates, p. 54 in J.A., p. 59.

Operator skill is of special significance because a major cause of complications using the D & E technique is infection resulting from failure to completely evacuate the uterus.[34/] An experienced physician, who has performed many D & E procedures, is more likely to have the skill to ensure complete uterine evacuation[35/] and to examine the products of conception to determine whether or not a complete abortion has taken place.[36/] Ambulatory surgical facilities which provide large numbers of abortions are more likely than general hospitals to be staffed with such highly experienced individuals.[37/]

[34/] Cates & Grimes, Deaths from Second Trimester Abortion by Dilatation and Evacuation, *supra* note 31 at Table 1.

[35/] Deposition of Dr. Willard Cates, p. 54 in J.A. p. 59. *See also*, *Id*. at 18, 27 in J.A., p. 48, 50.

[36/] Deposition of Dr. Willard Cates, p. 55, Defendants' Exhibit 1 on remand.

[37/] See *Id*. *See also* *Margaret S. v. Edwards*, 488 F. Supp. 181, 195 n. 40 (D. La. 1980), "It would not promote maternal welfare to compel women to obtain post first-trimester abortions in hospitals, where the doctors are almost totally inexperienced rather than to allow women to benefit from the clinic doctor's experience."

Other factors leading to superior clinic safety include increased incidence of infection in hospitals[38] and increased patient anxiety caused by lack of anonymity and exposure to staff who may disapprove of abortion.[39]

One reason that hospitalization does not enhance the safety of D & E abortions is that a major cause of complications, infection, does not arise until 24 to 72 hours after the procedure has taken place by which time the woman will have been discharged from either hospital or clinic. 664 F.2d at 690 n.6. Of course, as previously explained, clinic personnel are probably more adept in avoiding causing infection in the first place.

The other leading cause of death and complications in D & E abortion patients is hemorrhage.[40] Hemorrhage is also a late complication, most often related to an incomplete evacuation of uterine contents and rarely happens at the time of the procedure. Nevertheless, it has been suggested that these abortions should be performed in hospitals because such facilities are more likely to have blood banks.[41/] "Yet, performing D & E procedures in hospitals does not provide complete protection; 3 of 7 deaths from hemorrhage after D & E in 1972-1978 occurred in hospitals with blood banks."[42/] A properly equipped clinic can stabilize a hemorrhaging patient with intravenous administration of fluids and transfer by ambulance to a hospital with blood bank facilities.[43/] Guidelines of Planned Parenthood Federation of America (PPFA) and the American College of Obstetricians and Gynecologists for performance

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[38] Testimony of Judith Widdicombe, J.A. 100; Naim Kassar, J.A. 107-08; Robert D. Crist, J.A. 120-21; Allen S. Palmer, J.A. 131.

[39] Testimony of Naim Kassar, J.A. 106-07; Samuel Eubanks, J.A. 179.

[40] Note 34 supra.

[41/] Id. at 406

[42/] Id.

[43/] Deposition of Dr. Willard Cates, p. 47, J.A., 57.

of abortions in free-standing clinics require written transfer agreements with nearby hospitals in case of emergency.[44/] PPFA guidelines require that the clinic be located no more than ten minutes by ambulance from a hospital.[45/] Bleeding to death as a result of a D & E abortion is, however, an exceedingly rare occurrence.[46/]

The considerable track record of good medical care and low morbidity and mortality in the performance of second trimester abortion in free-standing clinics has led leading health organizations to abandon recommendations that all such abortions

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[44/] Planned Parenthood Federation of America, Inc., Manual of Medical Standards and Guidelines, Part One, Section VII-G 38 (December, 1981) (hereinafter cited as "PPFA Manual"). 1982 Manual of Standards for Obstetrical-Gynecological Services of the American College of Obstetricans and Gynecologists 16 (1982) (hereinafter cited as "ACOG Manual").

[45/] PPFA Manual, supra note 44 at 38. The district court in the present case accepted the plaintiffs' contention that life support systems would be adequately available at a local hospital. 483 F.Supp at 686 n. 10.

[46/] Out of 234,300 D & E abortions in the U.S. between 1972 and 1978, there were 7 deaths from hemorrhage. Cates & Grimes, Deaths from Second Trimester Abortion by Dilatation and Evacuation, supra note 31 at Tables 1 and 3.

be performed in hospitals. The American Public Health Association has now changed its position, originally articulated in 1970, and presently provides as its policy that,

> Current data show that abortions occurring in the second trimester can be safely performed by the Dilatation and Evacuation (D & E) procedure. D & E procedures are shown to be far safer than saline or prostaglandin instillation. Requirements that all abortions after twelve weeks of gestation be performed in hospitals increase the expense and inconvenience to the woman without contributing to the safety of the procedure. All instillation procedures are associated with lower rates of complications than that for hysterotomy and hysterectomy.47/

In March, 1980, the National Medical Committee of Planned Parenthood Federation of America approved the provision of abortions through the eighteenth week of gestation by the dilatation and evacuation method at selected affiliate free-standing clinics, if out-patient second trimester procedures are

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47/ APHA Recommended Program Guide for Abortion Services (Revised 1979), 70 Am. J. Public Health 652, 654 (1980) permitted by state law. The Committee's approval was based on a finding that "several studies have shown that, in programs conducted by experienced physicians, there are both increased safety and decreased costs of abortion with early second trimester dilatation and evacuation when compared with any other technique at this gestational stage, and with instillation techniques in the mid to late second trimester."[48] Finally, in its 1982 Manual of Standards for Obstetrical-Gynecological Services, the American College of Obstetricians and Gynecologists approved the provision of abortion in free-standing ambulatory facilities through the eighteenth week of gestation.[49]

In summary, established medical opinion now holds that early second trimester abortions may be performed safely in non-hospital surgical facilities and that there is no evidence to indicate that their safety is or would be enhanced by requiring hospitalization.[50] A hospitalization requirement for all second trimester abortions is, therefore, no longer a reasonable means of protecting maternal health and should be held unconstitutional.[51]

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[48] PPFA Manual, supra note 44 at 37.

[49] ACOG Manual, supra note 44 at 16.

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[50] *Amici* here take a position only on the performance of abortions by the D & E method in non-hospital facilities. It should be noted, however, that "there is data to show that initiation of (an) instillation procedure in a non-hospital setting with eventual completion of the delivery of the fetus and products of conception within a hospital is (also) safe." Deposition of Dr. Willard Cates, p. 41-42, J.A. p. 55.

[51] Even if there were some greater degree of safety associated with hospitalized D & E's, the fact remains that such abortions are virtually unavailable to Missouri women because only one Missouri hospital performs them. As a practical matter, therefore, Missouri women are forced to terminate pregnancies by methods more dangerous than the outlawed out-of-hospital D & E, that is by traveling to another state for an abortion, thus increasing health risks by delay, obtaining riskier instillation procedures at another Missouri hospital, self-aborting or getting an illegal abortion. Under the principles of *Planned Parenthood of Central Mo. v. Danforth*, 428 U.S. 52, 76-79 (1976) the state has the burden of showing that safer alternatives than the method outlawed are actually available in the state. Missouri has utterly failed to carry that burden here.

II. MISSOURI'S REQUIREMENT THAT ALL UNEMANCIPATED MINORS OBTAIN PARENTAL CONSENT OR COURT AUTHORIZATION FOR THEIR ABORTIONS PLACES AN UNDUE BURDEN ON MINORS' CONSTITUTIONAL RIGHT TO CHOOSE ABORTION

A. The Missouri Statute Does Not Allow Even A Mature Minor To Make A Decision Regarding Abortion Independently

The Missouri statute requires that any woman under eighteen who is unemancipated must secure the consent of one parent or, if she does not wish to consult her parents,[52/] a court authorization prior to obtaining an abortion. The statute directs the court considering a minor's request for an abortion to issue a decree "for good cause" containing one of the following three orders:

> (a) Grant(ing) the petition for majority rights for the purpose of consenting to the abortion; or

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[52/] The statute requires that the parent be notified when the minor brings a proceeding for court authorization. This section was, however, declared unconstitutional by the Court of Appeals. Planned Parenthood of Kansas City, Mo. v. Ashcroft, 655 F.2d 848, 860 (8th Cir. 1981).

> (b) Find(ing) the abortion to be in the best interests of the minor and giv(ing) judicial consent to the abortion, setting forth the grounds for so finding; or
>
> (c) Deny(ing) the petition, setting forth the grounds on which the petition is denied.

Mo.Ann.Stat §188.028. (Vernon)

Amici agree with the district court which initially considered this case, that the statute allows a judge to override the abortion decision of a mature competent minor and is, therefore, unconstitutional. 483 F.Supp at 690. For this reason, _amici_ urge this Court to reverse the decision of the Court of Appeals.

This Court has made clear that a minor has a constitutional right to choose to terminate her pregnancy. _Planned Parenthood of Central Mo. v. Danforth_, 428 U.S. 52, 74 (1976). Consequently, the state may not delegate a veto power to parents to deny that right. _Id_. The Court has nevertheless recognized that the state has an interest in ensuring that a minor make the important decision regarding abortion with the aid and guidance of her family and, therefore, may require parental consent or notification as a general rule. Recognizing, however, that some parents will refuse consent to abortion for arbitrary reasons and that some minors are unable or unwilling to consult their parents, this Court has held that a state imposing a requirement of parental consent for abortion must also make available to minors a meaningful alternative to mandatory parental involvement. Bellotti v. Baird, 443 U.S. 622, 640-44 (1979) (Bellotti II). This Court's decision in Bellotti II is clear as to what such an alternative must entail. First and foremost it requires that a minor be given an opportunity to demonstrate that she is mature and capable of giving informed consent to abortion. Id. at 643-44. If she is found to be competent to make the decision independently, she must be given authorization to give her own consent to the abortion, regardless of the presiding judge's view as to whether or not an abortion would be in her best interests. Id. at 650. The Missouri law fails to guarantee this right of choice to the mature minor.

First, as the district court held, the reviewing court is authorized by the statute to select one of three independent alternatives, all joined by the disjunctive "or," that is, grant majority rights or grant judicial consent or deny the petition. There is no requirement that the judge find that the minor is not mature as a prerequisite to denying the petition. The only stricture placed on a court is that the denial be for "good cause". 483 F.Supp at 689. In this sense, the statute is identical to the one this Court struck down in Bellotti II. Like the Missouri statute in this case, the Massachusetts law in Bellotti II allowed a mature minor's decision to be vetoed by a court which found an abortion to be against her "best interests."

The district court's view that the Missouri law does not preserve the constitutional rights of the mature minor is borne out by other aspects of the statute. Although the court is authorized to grant a minor "majority rights" to self-consent to an abortion, the term "majority rights" is not defined in the statute. There is certainly no indication that the phrase is equivalent to the "mature minor" rule enunciated in Bellotti II. Although the minor is required to allege in her petition that she is of "sound mind and sufficient intellectual capacity to consent to the abortion," §188.028.2(1), the statute does not limit the court's granting or withholding of "majority rights" to a determination of whether that allegation is true. In fact, the statute directs the court, in considering the minor's petition, to hear evidence on the nature, consequences and alternatives to abortion as well as the minor's ability to form a valid consent. §188.028.2(3). The lack of definition of the term "majority rights," together with the statute's failure to limit the court's permissible inquiry to matters relevant to the maturity issue, reinforces the district court's finding that a mature minor's abortion rights can be denied in Missouri for any "good cause."

The Court of Appeals re-interpreted the statute to give it an arguably constitutional construction. It said that a court would have to find that a minor was not mature and that an abortion would not be in her best interests as a prerequisite to denying her petition. 655 F.2d at 848. Such an interpretation simply does not flow logically from a statute that does not even mention the word "mature", or its equivalent, and in which the three decrees the court may order are not phrased as contingent upon one another but as independent alternatives.[53/]

By rewriting the statute to save its constitutionality the Court of Appeals engaged in the type of legislative activity long deemed inappropriate to the federal judiciary. In Bellotti II, the Massachusetts Supreme Judicial Court invited the federal district court to repair the statute so as to preserve its constitutionality. The invitation was declined.

[53/] That the statute does not and was not meant to comply with the strictures of Bellotti II is underscored by the fact that the Missouri legislature adopted it before this Court handed down that decision.

> It is commonly said that a statute is to be given a constitutional construction "if fairly possible" (citations omitted). Here something more is involved than construing language. The Massachusetts court, in addition to contradicting its specific terms, suggests reading into the statute affirmative provisions made out of nothing but a generally announced purpose to pass constitutional muster. In so doing, the court seems to have found the ultimate remedy for all constitutional infirmities. If a statute which, in terms, requires parental consultation without exception, can be "construed to require as much parental consultation as is permissible constitutionally," here, at once, is an instant cure, both for overbreadth, and for lack of standards. Regardless of whether a statute says too much, or too little, so long as the legislature intended it to be constitutional, when it comes before a court it will be appropriately rewritten. With due respect, we cannot believe this to be possible. Cf., United States v. Reese, 92 U.S. 214, (1875).

450 F.Supp. 997, 1005-06, affirmed 443 U.S. 622 (1979). See also, Roe v. Casey, 623 F.2d 829, 837-38 (3rd Cir. 1980).

B. The Missouri Statute Fails To Ensure A Confidential And Expeditious Proceeding For A Minor Who Does Not Wish Or Is Unable To Obtain Parental Consent To An Abortion

Central to this Court's holding in Bellotti II was the requirement that any alternative to parental involvement in a minor's abortion decision "must assure that a resolution of this issue, and any appeals that may follow, will be completed with anonymity and sufficient expedition to provide an effective opportunity for an abortion to be obtained." 443 U.S. at 643-44. The Missouri statute fails to so provide.

The statute provides that the minor's petition must be set for hearing within five days of the filing of a petition. §188.028.2(3). No time limit is given as to how long the court may take to render a decision once a hearing is held. Neither is any time limit given for appellate review if the trial court denies the petition. Although the statute recognizes that "time may be of the essence regarding the performance of an abortion" and directs the Missouri Supreme Court to provide for expedited appeals, §188.028.2(6). To date, three years since the statute was enacted, no such provision has been made. It is also noteworthy that the state court is directed to provide for expedited appeals but not for expedited decision at the trial level on the minor's initial petition. No provision is made in the statute for confidentiality other than allowing the minor to use her initials on the petition. §188.028.2(1).

Amici believe that even the most minimal delay possible under this statutory scheme will have serious health and emotional consequences for minors. Allowing five days between the time a minor files her petition and receives her hearing and the shortest possible interval for the trial court to render its decision and an appeal to be taken, taking into account clinic scheduling difficulties and the intervention of weekends and holidays, it is difficult to imagine that less than a week to ten days will elapse between the time a minor woman first visits her doctor and the time she finally receives an abortion. Even a week's delay increases by 50% the risk of dying during an abortion.[54] Worse still, a week's delay could well push a woman into the second trimester when it will be impossible for her to obtain an abortion in Missouri because the state requires all such abortions to be performed in hospitals and no hospital will admit a minor without parental consent. 655 F.2d at 854. She will then be forced to seek an abortion in another state, seek an illegal abortion or be forced to carry her unwanted pregnancy to term. The health risks engendered by the delay inherent in the Missouri scheme are especially aggravated for minors who out of ignorance, fear and lack of sophistication generally seek their abortions later in pregnancy than adult women.[55]

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[54] Cates and Tietze, Standardized Mortality Rates Associated with Legal Abortion: United States 1972-1975, 10 Family Planning Perspectives 109, 111 (1978).

The statute also fails to make provision for anonymity and confidentiality, other than allowing the minor to use her initials on the petition. Such provisions must be present in order for a judicial alternative to parental involvement to be meaningful.

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[55] See note 26, supra. The fact that the Missouri state court may promulgate rules to expedite appeal will not cure the inherent defects of the Missouri statute. First, as already stated, it is not authorized to shorten the five day wait between the time the woman files her petition and the date of her hearing, nor to prescribe a time for rendering of the initial decision, so that at least a week's delay is built into the statutory scheme.

"Indeed, if the right to privacy means anything, it means that the minor should be free to make her decision without fear that the decision she makes will be exposed to public scrutiny." Wynn v. Carey, 582 F.2d 1375, 1389 (7th Cir. 1978).

Clear procedures for confidentiality and expedited decision and appeal must be set forth in the statute. To relegate them to future or hypothetical promulgation of rules or to the discretion of the judge fails to give adequate protection to the privacy rights of young women. As the Seventh Circuit said, striking down a similar Illinois law,

> Because of the fundamental nature of the rights involved, because of the lack of legal sophisticiation of minors generally and because of the urgency inherent in an abortion decision itself, it is imperative that the procedure be spelled out in detail in the statute itself.

582 F.2d at 1389. And as this Court said in Bellotti II, "the need to preserve the constitutional right and the

unique nature of the abortion decision, especially when made by a minor, require a state to act with particular sensitivity when it legislates to foster parental involvement in the area" for "there are few situations in which denying a minor the right to make an important decision will have consequences so grave and indelible." 443 U.S. at 642.

Amici believe that Missouri has failed to legislate with the sensitivity required of it by the Constitution.

CONCLUSION

For all the foregoing reasons, the Court of Appeals' judgment that Missouri's requirement that all post-first trimester abortions be performed in hospitals is unconstitutional should be affirmed. The Court of Appeals' judgment that the requirement of parental or judicial consent for minors' abortions is constitutionally valid should be reversed.

Respectfully submitted

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August, 1982

Docket Sheet

NO. 81-1255-CFX
Vide: 81-1623

TITLE Planned Parenthood Association of Kansas City, Missouri, Inc., et al., Petitioners
v.
John Ashcroft, Attorney General of Missouri, et al.

DOCKETED
Jan. 4, 1982

COURT
United States Court of Appeals for the Eighth Circuit

DATE	PROCEEDINGS AND ORDERS
	Counsel for Petitioners: Frank Susman
	Counsel for Respondents: Michael L. Boicourt,
Jan. 4, 1982	Petition for writ of certiorari filed. (Record filed).
Feb. 10, 1982	DISTRIBUTED. 2-26. (Stricken)
Feb. 23, 1982	Response requested.
Mar. 26, 1982	Brief of respondents/cross-petitioners in opposition filed.
Mar. 31, 1982	DISTRIBUTED. 4-16.
Apr. 20, 1982	REDISTRIBUTED. 4-23. (Stricken)
Apr. 27, 1982	REDISTRIBUTED. 4-30. (Stricken)
May 10, 1982	REDISTRIBUTED. 5-13.
May 17, 1982	REDISTRIBUTED. 5-20.
May 24, 1982	Petition GRANTED. The case is consolidated with 81-1623 and a total of one hour is allotted for oral argument.

June 10, 1982	Order extending time to file the joint appendix and petitioners' brief on the merits until July 28, 1982.
June 19, 1982	Motion of Alan Ernest to represent children unborn and born alive filed. (Vide: 81-1623).
June 19, 1982	Motion of Legal Defense Fund for Unborn Children for leave to file a brief as amicus curiae filed. (Vide: 81-1623).
June 28, 1982	The motion of Legal Defense Fund for Unborn Children for leave to file a brief as amicus curiae is GRANTED. The motion of Alan Ernest to represent children unborn and born alive is DENIED.
July 23, 1982	Order extending time to file the petitioners' brief on the merits until Aug. 2, 1982.
July 26, 1982	Joint appendix filed. (Vide: 81-1623).
Aug. 2, 1982	Brief for the petitioners filed.
Aug. 2, 1982	Brief for cross-petitioners filed. (Vide: 81-1623)
Aug. 2, 1982	Brief, amici curiae, of Planned Parenthood Federation of America, Inc., et al. filed. (Vide: 81-1623).
Aug. 3, 1982	Brief, amicus curiae, of The National Abortion Federation filed. (Vide: 81-1623).
Aug. 4, 1982	Brief, amici curiae, of Certain Law Professors filed. (Vide: 81-1623)
	(Over)

81-1255

Title

No.

DATE	PROCEEDINGS AND ORDERS
Aug. 4, 1982	Brief, amici curiae, and Annexed Brief of the Committee for Abortion Rights and Against Sterilization Abuse et al filed (Vide: 81-1623).
Aug. 4, 1982	Brief, amici curiae, on Behalf of National Organization for Women, et al. filed. (Vide: 81-1623).
Sept. 2, 1982	Brief, amicus curiae, of The National Right to Life Committee, Inc. filed.
Sept. 3, 1982	Brief for respondents/cross-petitioners filed. (Vide: 81-1623
Sept. 20, 1982	Motion of The Legal Defense Fund for Unborn Children for leave to participate in oral argument as amicus curiae filed.
Oct. 4, 1982	The motion of The Legal Defense Fund for Unborn Children for leave to participate in oral argument as amicus curiae is DENIED.
Nov. 22, 1982	Reply brief of petitioners filed. (D).
Nov. 30, 1982	ARGUED.